

S. HRG. 110-805

# FIELD HEARING: CARING FOR AMERICA'S AGING VETERANS

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## HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE ONE HUNDRED TENTH CONGRESS SECOND SESSION

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JULY 3, 2008

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# C O N T E N T S

JULY 3, 2008

SENATOR

|                                                                                                                                                                                                                                                                              |           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Wicker, Hon. Roger F., U.S. Senator from Mississippi .....                                                                                                                                                                                                                   | Page<br>1 |
| WITNESSES                                                                                                                                                                                                                                                                    |           |
| Thomas, Bill, M.D., Founder, The Eden Alternative .....                                                                                                                                                                                                                      | 3         |
| McAlilly, Steve L., President and Chief Executive Officer, Mississippi Meth-<br>odist Senior Services, Inc. ....                                                                                                                                                             | 5         |
| Prepared Statement .....                                                                                                                                                                                                                                                     | 9         |
| Cutler, Lois J., Ph.D., Research Fellow, School of Public Health, Division<br>of Health Policy and Administration, University of Minnesota .....                                                                                                                             | 12        |
| Prepared Statement .....                                                                                                                                                                                                                                                     | 13        |
| Attachment .....                                                                                                                                                                                                                                                             | 15        |
| Jenkins, Robert, MSRE, Director, The Green House® Project, Vice President,<br>Community Solutions Group .....                                                                                                                                                                | 23        |
| Prepared Statement .....                                                                                                                                                                                                                                                     | 25        |
| Attachment .....                                                                                                                                                                                                                                                             | 29        |
| Hojlo, Christa, Ph.D., Director, VA Community Living Centers and State<br>Veterans Home Clinical and Survey Oversight, Office of Geriatrics and<br>Extended Care, Office of Patient Care Services, Veterans Health Adminis-<br>tration, Department of Veterans Affairs ..... | 32        |
| Prepared Statement .....                                                                                                                                                                                                                                                     | 34        |



## **FIELD HEARING: CARING FOR AMERICA'S AGING VETERANS**

**THURSDAY, JULY 3, 2008**

U.S. SENATE,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.*

The Committee met, pursuant to notice, at 10:35 a.m., In The First United Methodist Church, Tupelo, Mississippi. Hon. Roger F. Wicker, Member of the Committee, presiding.

### **OPENING STATEMENT OF HON. ROGER F. WICKER, U.S. SENATOR FROM MISSISSIPPI**

Senator WICKER. Well, thank you very much. I want to tell you, as a member of the Senate and as a veteran myself, I very much believe in punctuality. But the press grabbed me, and Kyle Stewart tells me, when the press wants to quote you or give you a little publicity, it is a good thing to cooperate, even if it makes us a minute or two late. So, welcome. We will have a few introductory words and then begin. At this point, I would ask that all of us stand for the flag presentation which will be made by Troop 12, a troop where my son, Daniel, achieved the rank of eagle scout. Troop 12 is a part of the Yocona Area Council.

[Whereupon, Troop 12 presented the flag of the United States of America.]

Senator WICKER. Thank you. And our pledge will be led today by Mr. Rex Mooney, president of the Vietnam Veterans of America, Chapter 842. Brother Pastor, after the pledge, I am going to ask you to come up and lead us in an invocation.

Mr. MOONEY. Please join me in the Pledge of Allegiance to our flag.

[Whereupon, the Pledge of Allegiance was recited by all present.]

PASTOR. Let's pray. Lord, on this day of a new beginning of a new day, we honor You with our lives. We remember how we are to respect our elders and those who have given of their service. And so we come today to deliberate, to understand what it is that makes our Nation great, to honor those who have come before us who have given sacrificially of their lives. We remember this because of Your sacrificial giving of Your Son and our Savior. So be present in this hearing. May we honor You with our lives. Be in our speech and be in our hearts and be in our action. Be in all that we do for the sake of Your kingdom, amen.

Senator WICKER. Thank you, Brother Andy. You may be seated. I very much appreciate your attendance today, and welcome to this field hearing of the U.S. Senate Committee on Veterans' Affairs

dealing with the subject of caring for America's aging veterans. At this point, I want to introduce to you two Members of the Committee staff who have traveled from Washington, DC, to be with us today. And stand as I call your name. Aaron Sheldon. Aaron is a staff member for the Chairman of the Senate Committee, Senator Daniel K. Akaka of Hawaii. Then, John Towers, please stand. John is a staff member for Senator Richard Burr of North Carolina, the Ranking Minority Member of the Committee. We appreciate these staff members taking their July 3rd to come here and be with us today.

Now, we have a distinguished panel of witnesses that I will speak more about later, but let's just have them, at this point, stand and turn around, if you don't mind, so that we can make sure that we get a face with a name. Dr. Christa Hojlo—now, did I pronounce that correctly?

Ms. HOJLO. Yes, sir.

Senator WICKER. I think I butchered it pretty bad on public radio this morning. But just think of high and low. Dr. Hojlo is director of VA Community Living Centers and State Veterans Home Clinical and Survey Oversight. Then, next to her—and we'll just go down the line—Dr. Bill Thomas, founder of The Eden Alternative; then, in the center, our own Tupelo representative, Steve McAlilly, chief executive officer of Methodist Senior Services, Incorporated; then Robert Jenkins, director of The Green House Project; and Dr. Lois Cutler, research fellow, School of Public Health, Division of Health Policy and Administration, University of Minnesota—came all the way from Minnesota. So, thank you, and let's give a warm Mississippi welcome.

I am going to make just a few remarks, and then we will take testimony individually from each of these witnesses. I'll give Dr. Thomas warning that I will ask Dr. Thomas to go first. But welcome to this hearing. I did not realize, until we got into this, that I am the first Mississippi senator ever to serve on this particular Committee—the Senate Veterans' Affairs Committee. We have had many distinguished Mississippians precede me in the halls of the U.S. Senate, but they have served on other very important committees. I am glad to be holding this Committee hearing in Tupelo, Mississippi.

Now, Tupelo is famous for many things. We had a big tornado one time. We have a native son named Elvis Presley, who hasn't been around here very often recently. And we're proud of the many accomplishments that we have made, in terms of job creation and manufacturing and economic development; but increasingly, this city has become known as the birthplace of a revolution in long-term health care. In Mississippi, actually, we are proud to be on the cutting edge of long-term health care reform. We're here today to discuss ways to keep that momentum going and consider how we might expand the successful formula that we have put into place here known as The Green House Project, to work within the Department of Veterans Affairs and the VA system.

These distinguished witnesses have, I think, set some sort of record for long distance traveled to a Senate Veterans' Affairs field hearing, and I do appreciate their attendance today, as well, of course, as the staff members. And thank you all for coming and

participating. We have many veterans here, and we have representatives of a number of the veterans service organizations. So welcome, and let's begin the testimony with Dr. Bill Thomas. He is the one who started this excitement. Do we call you Bill or William?

Dr. THOMAS. Bill is fine.

Senator WICKER. Bill is OK. Bill is a geriatrician and a trailblazer in the realm of elder care. He developed the Green House model and created The Eden Alternative to help facilitate long-term care transformation in the United States of America. Dr. Thomas, welcome, and proceed in your own fashion. We're glad to have you.

**STATEMENT OF WILLIAM H. THOMAS, M.D., FOUNDER,  
THE EDEN ALTERNATIVE**

Dr. THOMAS. Thank you very much, Senator. And thank you for hosting this hearing, and thank you for holding it in Tupelo, Mississippi. I think it is very important that we draw attention to the fact that the first Green Houses were created right here in this community by pioneers from this community.

I have given thought, of course, to what I wanted to say to you and to the Committee, and I will leave it to others to talk about some of the details about the Green House. I think that is important, but I thought I might spend some time talking about the nature of the field of long-term care, in general, and the nature of change in that field; and what is going on; and how I believe our veterans should be benefiting from the improvements in the field of long-term care that are underway right now.

Let me say, first off, that historically, it is our Nation's commitment to veterans that started us down the path of providing care to older, frail, and disabled people. It was actually after that—what I'll refer to as the War Between the States, otherwise known as the War of Northern Aggression—it was after that conflict that our governments, respectively, started making a provision for commitment to veterans. And, indeed, that commitment was expanded upon, enlarged after World War I, and again after World War II. So, in fact, it's been an important part of the fabric of our national promise to our veterans that we would provide for them in their later years as they provided for us in their earlier years.

Now, early on, that promise was delivered in the form of institutional long-term care. We, as Americans, I think, as we're prone to do, we followed the logic of economics, economies of scale. We followed the logic of the Division of Labor and created large institutions that focused primarily on the tasks that needed to be accomplished and put those tasks, unfortunately, ahead of the people being served. And the result was really what we have come to know in America as the 16,000 long-term care institutions created and are currently being managed today—16,000. And I would like to point out something that people often don't realize; there are more nursing homes in America than there are McDonald's restaurants. It is a fundamental part of our health care system, and it is increasingly clear that it is based on flawed assumptions from decades and decades ago.

So, what is changing? What is changing is an industry-wide acknowledgment that you have to put the person first. You have to put relationships first, that economies of scale cannot and do not apply to human relationships. Fundamentally, long-term care is, more than anything else, about the care. And care is a habit of the heart. It is a human activity, and it does not scale up the way a furniture factory does, where, clearly, it is better to build a bigger factory and a bigger assembly line, because it is more cost effective.

What we're increasingly learning—and I think Dr. Cutler will address this, in part—is that it is not cost-efficient to attempt to scale up human relationships and caring. Because what happens is people begin to feel lost. They begin to feel that they are just a number. And I think it is wrong in all circumstances, and I think it's particularly wrong when that kind of existence is what we offer to our veterans.

So, what is changing? We're learning to put the person first. We're learning to create small scale environments where relationships matter most. And I think our veterans deserve the benefit of this research. I know that some of the other speakers are going to talk about some of the research funding and the grants that are being made to support this. I think it is really essential that our veterans get the full benefits. And I'll close, actually, my comments with a simple analogy that I use that is really effective for me in my work. I grew up in a rural area, a good close-knit small town family. And one of the things—

Senator WICKER. Where did you grow up?

Dr. THOMAS. Upstate New York—a fine, fine place.

Senator WICKER. Absolutely.

Dr. THOMAS. I am actually the grandson of World War II veterans, and my boy, I'm proud to say, is enlisted in the United States Coast Guard. So it is personal to me, as well. So my feeling about this is—my family taught me that—sometimes half a loaf is better than no loaf at all. And I grew up understanding that you don't always get what you want, and sometimes you have to have something for less than you might have preferred. But my work on the reform movement of the Green Houses has taught me another lesson, and that is: sometimes it's not about half a loaf, it is about getting it right.

I sort of imagine what it would be like to tell our service people, you know, half an aircraft carrier is better than no aircraft carrier. Half a fighter jet is better than no fighter jet. Half a tank is better than no tank. Well, it doesn't make sense. People need the tools that are properly created and properly designed to do the job you're asking them to do. And one thing I want to make clear to the Committee and Committee staff, and to you, Senator, is that I think it is very important that, as the Veterans' Affairs Committee looks at this, and the agency looks at this, that you understand that the Green House is a complete model created to do a specific thing, and that is to create a life worth living for the people it houses and shelters; and that taking one piece, or half of it, or one little part and calling that enough is a mistake. Just as providing our service people with a one-winged aircraft would be a mistake.

This is a case where we have to get the whole thing, because in order for it to work effectively—and I'll leave it, for example, to

Steve McAlilly to talk about the experience right here in Tupelo—this is a case where half-measures are not necessarily the desired outcome. So, you have given me the honor of your attention and the honor of testifying before you, and I want to say thank you very much.

Senator WICKER. OK. I think I am going to change the order here. First of all, can everybody hear in the back? I think, Mr. McAlilly, I am going to go to you next, if you don't mind. But I want everyone to understand exactly what we're describing here. I think what we have said is that this is an innovation that began here in Tupelo. It has moved to other sections of the State of Mississippi now. United Methodist Senior Services has been very active in this, and without which, we probably wouldn't be here today.

We want the best care possible for everyone, but certainly for someone who has served our Nation in the armed services and kept us free and risked life and limb during the time of conflict. We deserve and they deserve the very best that we can provide. And we have heard from Dr. Thomas that this involves relationships, and we're trying to research this. But, Mr. McAlilly, you have got your testimony in front of you, and I don't want to throw you off, but I would hope that you could describe, for those who have not been out to the Green Houses here in Tupelo, exactly how it looks, how it differs from traditional long-term health care, and why you think it is better.

Now, having thrown you that curve, we welcome Steve McAlilly. Let me tell you a little more about him—CEO of Methodist Senior Services here in Tupelo. His leadership and vision were important in advancing a new, and at that time, unproven concept in long-term health care. Perhaps you can discuss, Mr. McAlilly, whether that has now been proven. We look forward to hearing your insights, and we appreciate your work here locally and your willingness to be part of this hearing. Steve, take it away.

Mr. McALILLY. Thank you, Senator Wicker. We welcome you back home.

Senator WICKER. Well, thank you. It is good to be home.

By the way, your prepared statements will be made part of the permanent record for the Committee. We appreciate that.

**STATEMENT OF STEPHEN L. McALILLY, PRESIDENT AND CEO, MISSISSIPPI METHODIST SENIOR SERVICES, INC., TUPELO, MS**

Mr. McALILLY. And we're honored to be here with you and the staff members from the U.S. Senate and this panel of witnesses. We are honored to be able to have this chance to talk about the very thing you mentioned. I feel a little bit like Dustin Hoffman in the movie Tootsie with the curve you just threw me, except I'm not the one throwing the curve. You were. I hate to be stuck to a script, so I was already thinking of varying from that, anyway. So that will fit just well.

Essentially, a Green House is a small group home for 10 or fewer elders who need skilled nursing care or assisted living services. The design is crucial to it, just as the keystone of an arch is crucial to the arch. If you pull the design, you pull the space away, and the whole thing falls, we believe. In that small group home, we provide

private rooms and private baths for the elders. There is a hearth in the center of the house with recliners from Sam's; and everybody has their favorite chair and their favorite spot. The kitchen is like a great room. The kitchen is right there. There is food always available, like there is at home. They can go into the refrigerator or eat cookies off of the kitchen counter—their kitchen counter.

There is a big table next to the kitchen where all of the elders and the staff members sit down together and eat. And the way we—I don't think operate is the right word—but the way it functions is just like at your house. The kitchen table, I would bet, is the most sacred space in your house, and if your best friend comes over at mealtime, you're going to put a plate out for them, and they will join in fellowship and activity at the kitchen table, rather than go into the dining room with the fancy china and sit down. That's the way we function in a Green House. And we've had family members develop weight problems because they come over and eat, because the food is so good.

Senator WICKER. That is another Mississippi problem.

Mr. MCALILLY. Dr. Thomas describes it—and I steal his words all of the time, and he knows it. I think I have permission, and usually I give him credit, but he describes it as the world's most inefficient nursing home or the world's most efficient home health delivery system. The nurses come over and ring the door bell, just like they would if you were having home health brought into your home. And they come in, and they do their nursing. They do their medical treatment, and then they locally have 10 clients there within 6500 square feet, rather than 10 clients scattered all over Tupelo, Mississippi. And they do their thing, and then they leave and go to the next house.

The house revolves around the elders, the people who live there. And we make decisions and we put the resources as close to the elders as possible, because that's where they make the biggest difference. So what that means to us, they are dollars that go into buildings. And so the building is better. It is home. It costs a little more than a traditional semiprivate nursing home. It does. But we move those dollars that are in the system to the front line, where they make the biggest difference. The other part of that is the staffing levels among the front line staff, and pay. I will go ahead and put this word out there. It used to be hard to say this in Mississippi. The front line staff member is a shahbaz. And that means—

Senator WICKER. How do you spell that?

Mr. MCALILLY. S-H-A-H-B-A-Z, and it comes from a great story that Bill Thomas tells about the first shahbaz. It's a Persian word that means, "royal falcon," and it's given to the CNA—the certified nursing assistants. They are the shahbazi. That is the plural of shahbaz, or so Bill tells us. We believe it, anyway. But, it has given them a new purpose and function. Their job is to protect, sustain and nurture the elders who live in their house. They cook. They do light housekeeping. They do the personal laundry. They oversee and participate in the activities in the house. They are a self-managed work team. They self-schedule themselves.

And just in terms of growth of people who work there, we have seen astounding results like decrease in turnover, and just self-

worth. They have become people—they were people stuck in jobs that, I think, the system caused them to be smaller than they were. But in this vessel, in this system, in this house, in this space, they have been enabled to become who they were created to be. Now, that is the first part, I think, of what is a Green House—a small group home where we do skilled nursing care. But the other piece is the culture.

Senator WICKER. The same people who would be admitted, traditionally, to a nursing home——

Mr. MCALILLY. Absolutely.

Senator WICKER [continuing]. As we have known to expect it, are housed in the Green House.

Mr. MCALILLY. Cared for in the Green House. There has not been a person yet in Tupelo, Mississippi, in our Green House homes that, because of their frailty or medical needs, that we haven't been able to serve in a Green House. They are designed to provide everything, in terms of treatment and care, that the traditional nursing home was designed to provide. And we do it.

People are doing that in Tupelo every day. The people who have the finances to provide 'round the clock care, they are doing it. And that is why, to us, it is not that novel. It is just, duh, that kind of reaction. Why did we ever do it the other way? Because people still do it, and people are cared for there in their homes, if they have the money to do it. But in this system, there is the money there to do it right now, today. And we have proven that over the last 5 years.

Senator WICKER. OK. Let's do this, Steve, let's take another 4 to 5 minutes on your testimony, and then I'll have a couple of questions. And I think we'll probably have an opportunity for some back and forth. Can everyone hear?

UNIDENTIFIED SPEAKER. We're having a little of trouble hearing the——

Senator WICKER. OK. We'll ask the witnesses to speak right into the microphone. I think it is on. Just speak—just put your mouth right up to it like you are Mick Jagger.

Mr. MCALILLY. Can you hear me now? Basically, as we started this journey—you met Bill Thomas, and when he talked about relationships, that's what it is about. And it started with the relationship that he and I developed that's gone on now about 10 years. And as you heard, when Bill talks, he talks about truths with a capital T. And the truths that he talked about in Eden Alternative made perfect sense to us.

We started this journey in 1994. We wanted to build a nursing home. We believed the essence of dignity was a private room with a private bath. We didn't understand why, when people got old and frail, they had to move in with a stranger with a sheet pulled between their beds. That just didn't sound right to us. The other thing is we wanted to create a place, as we built this new nursing home, in which the children of frail elders would feel pride, rather than guilt, that their parents were living there.

So we started this journey looking for the best design. And Bill started talking about the Eden Alternative, and we got to know him. And we realized we were asking the wrong questions, and the system is asking the wrong questions. The stakeholders asked,

what quality insurance and total quality system can we put into a nursing home to improve quality? What the question really ought to be is, why has proven quality systems in other industries not made much of a difference in a nursing home? The stakeholders asked, what type of regulations or penalties can we put on people who are operating nursing homes so that they will improve compliance, when the question ought to be, what is wrong with the system that, no matter how many regulations and how tough penalties are, that quality and satisfaction is not consistently changed?

The stakeholders asked what oversight and control can we put on this industry to improve outcomes? Here's what you have got, you've got a CMS, State Departments of Health, State Medicaid division, ombudsmen, State Attorneys General, looking over this industry's shoulder. The question is, what is wrong with that picture? Why does this industry need that much control and oversight? And the bottom line is people still say a short prayer when they walk in the door of a nursing home. God, save me from this.

And so we started asking those questions and moving along, and we came up with a wonderfully-designed nursing home. And Bill, pick my brain—it was going to be a 140-bed replacement for Cedars Health Center on the Traceway Campus, a state-of-the-art design with 20-unit neighborhoods, or pods, and a town hall in the middle that would remind them of home. And we were proud of what we had come up with.

One day Bill was in Mississippi, and we were talking, and I was enthusiastically describing that nursing home, and he says, "you know, I don't think that's what we ought to be building anymore." And that question haunted me for a long time. Then he came up with the Green House concept.

To the credit of the good people in Tupelo, our board of directors here had the courage to stop that project that we had invested thousands of dollars in, and evaluate Bill's ideas. And when we did, we realized they made sense. We realized that the question was home, not home-like. The question was, why do we do it this way? Why was this ever a good idea? The question is, why don't we cook the food in the presence of the elders, instead of having it carted down the hall? The ideas just made plain sense to us, and as a matter of intuition and a matter of heart, our board of directors had the courage to go off on this idea without scientific data.

Now, I think Dr. Cutler will talk about the research data that verifies that we were right, but our anecdotal data is that people who were in wheelchairs are walking again. People who wouldn't eat in the nursing homes started eating and gaining weight again. People who hadn't had a visit from a friend or a family member in years started having company again. Family members, as I mentioned, started gaining weight. Every way you look at it, it's been good.

Now, it is hard, because we're not transforming something. It is not just the design, it is the culture. We're replacing the whole culture. And when you get to deal with changing people's paradigms, it is hard. Sometimes the paradigms filter the data so that we don't see the need to change. I think that's really where we are in the system.

[The prepared statement of Mr. McAlilly follows:]

PREPARED STATEMENT OF STEPHEN L. MCALILLY, PRESIDENT AND CEO,  
MISSISSIPPI METHODIST SENIOR SERVICES, INC., TUPELO, MS

My name is Steve McAlilly and I am the President and CEO of Mississippi Methodist Senior Services, Inc., a 501(c)3 not-for-profit corporation that provides housing and long-term care services to elders in eleven locations in Mississippi. Among our 1,600 residents, over 30 percent receive either Medicaid assistance or housing assistance through HUD's programs for low-income elders.

In May 2003 we opened the Nation's first Green House homes here in Tupelo. Now, five years later, we are even more convinced that this model of care is the right thing to do.

Our journey actually began in 1994 with a realization that something was wrong with the way elders were being treated when they needed skilled nursing care. We recognized that most people said a short prayer when they entered the doors of a nursing home: "God, please save me from this." We intended to do something about that, but had no idea at the time where it would lead. Our guiding vision on the journey was that we believed the essence of dignity for elders started with a private room and a private bath. And we intended to create the kind of place that children of frail elders would feel pride, rather than guilt, that their mothers and fathers lived there.

We began to realize that the system of long-term care was broken; that it was giving the kinds of results it was designed to give and no one was satisfied with those results. More than that we realized that everyone connected to long-term care was asking the wrong questions:

- The stakeholders ask, "What quality assurance or total quality management system can we put in place to improve quality in nursing homes?", but the right question is "why do sound and proven quality systems in other industries not consistently give us the results we are looking for in nursing homes?"
- The stakeholders ask, "What tighter regulations and tougher penalties can we develop to force compliance in nursing homes?", but the right question is "what is wrong with a system that no matter how tight the regulations and tough the penalties, results do not significantly and consistently improve?"
- The stakeholders ask, "What form of oversight and control can we develop to ensure compliance and quality in nursing homes?", but the right question is "why does this industry require oversight from CMS, State Medicaid Divisions, State Departments of Health, State Attorneys General and Ombudsmen—at least five major agencies—and the industry is still not meeting expectations?"

As we began to realize what the right questions were, we started designing. Little did we know we were still on the wrong track—a better one to be sure, but wrong. Our searching for the best designs and systems led us to a friendship with Dr. William H. Thomas, the founder of The Eden Alternative. Even there, though, we were about to make a \$12,000,000 mistake—a state-of-the-art institution with rooms arranged in "neighborhoods" or "pods" of about twenty residents and a wonderful "town square" in the center to remind the residents of their homes. Bill Thomas started talking about something he called "Green House." It made sense: home, not home-like; small detached homes for ten or fewer elders who needed nursing care; systems designed around the elder rather than medical treatment; resources like money, buildings and staff moved as close to the elder as possible.

Our board of directors had the courage to stop our \$12 million state-of-the-art project in its tracks and to study Bill's ideas. We forged out to implement and pioneer the ideas . . . at a time when there was no "scientific data" which pointed in that direction. It was a matter of intuition, a matter of heart, that led us on down that road. We understood that if the world has to wait on scientific data to change a paradigm or start a revolution, we would still be riding trains, rather than flying, across the country.

*We learned the right questions are about home, and making a home for the elders.*

As I said, now five years later, we are even more committed to the concept. The results, both anecdotally and scientifically, prove we were right:

Dr. Rosalie Kane, Ph.D., University of Minnesota, reports after 30 months of research:

- Residents report better quality-of-life and greater satisfaction
- Family members report greater satisfaction with relative's care and life
- Family members report greater satisfaction with how they as family members were treated
- Staff felt more empowered to assist residents, knew residents better
- Staff experienced greater intrinsic and extrinsic job satisfaction and were more likely to remain in the job

- Minimum Data Set-based Quality Indicator analyses showed either no difference in Quality Indicators or statistically significant advantages for GH
- Less Activities of Daily Living decline, less prevalence of depression, less incontinence without a toileting plan, less use of anti-psychotics without a relevant diagnosis

Dr. Kane summarized her findings at a recent meeting of the American Association of Homes and Services for the Aging: “I have never seen such good results that tell such a consistent story over time”, outcome findings are “robust in support of Green House for residents, family and staff”, “staff findings are striking, suggesting staff empowerment is possibly a vehicle for resident outcomes.”

We have a lot of anecdotal evidence that this makes perfect sense:

- People in wheel chairs are walking
- People who would not eat food in the nursing home are eating again and gaining weight
- People who would not talk are talking again
- Agitation levels of people with Alzheimer’s Disease are significantly lower—there is a sense of peace in the houses
- Families are involved in the lives of the elders like never before
- So many children visit that one house had to develop guidelines for children visits
- Independent living campus residents are visiting—they avoided our nursing home like the plague, affectionately calling it “that hell-hole down the hill”
- The nursing staff and front line workers (CNA’s) have developed a sense of team-work and collaboration, seeing each other as equal, important members of the team
- Absenteeism and turnover are virtually non-existent—in fact overtime is our problem; they come to work too much, “just to help out and see how everyone is doing”

Is it the design, or the culture? I believe that it is both. I do not believe you can “put new wine into old wineskins”, that the design and the culture go hand-in-hand—they are interdependently responsible for the results. The design is like the keystone in an arch—pull it out and the whole thing falls.

The old system is designed to give us the results we are getting and no improvement or tinkering with the basic system will give us anything more than the results we have always had. Our paradigms have blinded us to the data that tells us the system is broken, so not seeing the data, we do not see the need to change—we have become inoculated and accept that, and even believe, that we are doing a great job; and we are, as much as you can in this system.

I believe that each Member of this Committee knows this:

- There is a difference between food prepared in your presence in your kitchen and food carted in from a central kitchen.
- There is a difference between six to ten friends sitting around their kitchen table together, having fellowship and fun around the partaking of good food and 120 people in tables of four, hurriedly being fed so the dining hall can be cleared for the next activity.
- There is a difference between a few friends sitting around their kitchen table playing Rook together and a bingo game in the activity room with 60 people.
- There is a difference between eight people sitting in their hearth, in their favorite chair (a recliner from Sam’s) and 45 people lined in their wheel chairs in the hall or day room, waiting.
- There is a difference between being able to walk out of your bedroom into your den, or even onto your patio to tend your flowers and walking down a mock street to the mock town square.

*There is a difference between home and home-like; between home and an institution.*

Thirty years ago we did not know better. Twenty years ago, even 10 years ago, we did not know better. We were doing the best we could with the best information we had. Today, we know better. We have the scientific data. We have the anecdotal data. The results have proved this new system, this new wine in these new wineskins, makes all the difference in the world.

Today, on the eve of our country’s birthday, I suggest that you can make a difference in the lives of those who have given their all for their country—those who have answered the ultimate call of patriotism to risk their lives for their country and freedom. They, more than anyone, deserve the best we can give them. They deserve the difference between home and home-like; the difference between home and institution.

Senator WICKER. OK. Now, we're going to put your whole statement in the record, and then you can get back to us and make some other points that you would like to, after the others have had a chance to talk. How long have we now had Green House nursing home care in Tupelo, Mississippi?

Mr. MCALILLY. Since May 2003, just over 5 years.

Senator WICKER. OK. I think I was there for the opening of that one. It's hard to believe it's been 5 years. How many people are currently housed in that type of care here at the Tupelo campus?

Mr. MCALILLY. There are 112. We started out with four homes of 10 persons each, and then we opened six more the fall after Katrina hit. And those houses have 12 persons each, so we have 112 people who live in Green House homes here in Tupelo. We have another two Green House homes on one of our other campuses that provide assisted living, and we're building six more 10-person homes in Yazoo City, as a part of the Martha Coker home system there.

Senator WICKER. Does United Methodist Senior Services have what we would call traditional nursing home kind of beds?

Mr. MCALILLY. We do.

Senator WICKER. And that is all over the State?

Mr. MCALILLY. We have three—including the Traceway campus. We have two other campuses with traditional nursing homes: Trinity Health Care in Columbus; and Doogan Home in West Point.

Senator WICKER. OK. How do you decide who goes to the Green House and who goes to the more traditional nursing home?

Mr. MCALILLY. Well, the first level is the people in the Columbus area want to stay in Columbus, so they apply to move to Trinity Health Care. Here in Tupelo, Traceway Campus, as you know, is large and has about 420 total people that live on that campus. Those people have—they are people who are living independently in cottages and apartments. People who need assisted living are at the Mitchell Center. Those people have first priority to move into a Green House when their care needs get that high. And then, if we have space or openings, the greater Tupelo community is able to move in. And it's on a—we need to put your name on a waiting list. And we've had, in essence, 99 percent occupancy and a long waiting list since we opened.

Now, the first 40, they were pioneers, too. Our medical director at the time thought we were crazy for moving those people out there in the woods. Now, if you talk to him, he thinks he invented the thing, and we let him think that. We're proud for him to say it was his idea.

Senator WICKER. Well, thank you for your testimony. Our next witness, as I said, is from the University of Minnesota, Dr. Lois Cutler. Dr. Cutler was part of the team that studied the Green Houses in Tupelo. I'm told they found multiple outcomes that we'll hear about today, and these outcomes have given credence to Dr. Bill Thomas' vision and proved his hypothesis—that there is a better way to handle long-term care.

Dr. Cutler, is that true? Is this the wave of the future, or is this just a nifty thing that we're spending a little extra money on here in Tupelo that we can't replicate?

Ms. CUTLER. Our hope is that it is the wave of the future.

Senator WICKER. OK. Let me just ask you to get right up next to that, just scoot right up next to that microphone. My dad is on the next to last row. He is 80-hmmhmm years old, and he wants to hear you.

Ms. CUTLER. OK. My hope is, our dream is, our expectation is that it is the wave of the future. We can change, and our data has shown that this is a good model of change.

**STATEMENT OF LOIS J. CUTLER, Ph.D., SCHOOL OF PUBLIC  
HEALTH, UNIVERSITY OF MINNESOTA**

Ms. CUTLER. Now, Senator Wicker and ladies and gentlemen, my name is Lois Cutler, and I am one of the researchers that studied the effects of the first four Green Houses in Tupelo, Mississippi, the outcomes for the residents, residents' family members and front line staff. My background is in housing and design, as well as gerontology. This testimony also reflects the views of Dr. Rosalie Kane, the director of the study. For the record, we would like to include the article on a Green House study that was published in the prestigious *Journal of the American Geriatrics Society*.

Senator WICKER. That will be made part of the record.

Ms. CUTLER. Thank you. We conducted research over the first two-and-one-half years of the Green House experience, and we compared the results to the traditional nursing home on the same campus and a second traditional nursing home, Trinity, located about an hour and one-half away. At four points in time—each 6 months apart—we interviewed residents, family members, and all nurses-aid level staff at the Green House and at the two comparison studies. We also compared results of the minimum data set, the MDS, a national assessment protocol conducted in all nursing homes, for the residents in the three settings.

I personally spent many, many, many hours observing how the space was used in the Green Houses. Were residents with dementia using the space differently? And I also wanted to see how the staff and the visitors used the physical space. And what we found is the Green House residents experience a better—and this means there are significant findings—the Green House residents experienced a better quality-of-life on many dimensions of quality-of-life that we measured, and are even more satisfied with the services in the nursing home and the place where they live. Now, this is just a generic version of all of the findings that you'll find in the article.

Family members—our Green House residents spent more time visiting, and we calculated the time, were more satisfied with the residents' care, and were more satisfied with how their own needs, as family members, were met. For example, they were better satisfied with their own communication with the nursing home. Compared to the nurses-aid level staff in the comparison nursing home, residents' assistants in the Green Houses had more intrinsic success and were more likely to believe that they had the ability to bring about better outcomes for residents in psychological and social dimensions, that they knew the residents in their care better and were more likely to remain in the job.

And for me, personally, the staff change is one of the key models or key parts of this concept. The staff, they were partners in everything they did. Using the quality indicator measured nationally for

all nursing homes, the results for Green House residents were as good as in a comparison setting—in a few cases, better. This is important because we want to make sure that no harm was done to quality of care with the greater freedom and quality-of-life experienced by Green House residents.

Elders in the two Green Houses that were dementia-specific functioned better in the Green Houses than in their previous space in the large dementia care units. We speculate that the Green Houses are successful because of the small scale and the emphasis on normal quality-of-life and because of the model of caregiving that allows front-line staff and other staff to really know the residents. The Green Houses are also successful because of the physical setting, and we feel the private rooms are incredibly important. And inviting shared spaces evoke a particular kind of behavior for residents and staff alike.

We are pleased that the Veterans Administration is considering developing similar small house model nursing homes at the Trencle Administration Medical Center long-term care programs, including the nursing home care units and long-stay units. The model should be adaptable to many veterans in the medical center campuses, particularly those where the nursing homes are older and are slated for rebuilding, and where land is available to build a small-house style nursing home. Although, perhaps, not in the scope of this committee, we also believe that this model is very suited to nursing homes in the State veteran homes that are operated by many State governments in partnership with the VA and the local veterans medical center.

The Veterans Administration programs are characterized by a high degree of professionalism among the staff members, in nursing, social work and other fields, and has shown historic leadership in clinical geriatrics and geriatric team building. Some of the building blocks for a successful Green House project are, therefore, already in place. A small-house nursing home program such as the Green House requires a high degree of skill, flexibility and commitment from those who will serve as leaders, educators and middle managers. Please read the article, and you will find more results, but this is an overview, and we did find the concept to be very, very successful. Thank you.

[The prepared statement of Ms. Cutler follows:]

PREPARED STATEMENT OF LOIS J. CUTLER, PH.D., SCHOOL OF PUBLIC HEALTH,  
UNIVERSITY OF MINNESOTA

Senator Wicker and Ladies and Gentleman: My name is Lois J. Cutler and I am one of the researchers that studied the effects of the first four Green Houses in Tupelo, MI, on outcomes for residents, residents' family members and frontline staff. My background is in housing and design as well as gerontology. This testimony also reflects the views of Dr. Rosalie A. Kane, the director of the study. For the record, we would like to include the article on our Green House study that was published in the *Journal of the American Geriatrics Society*.

We conducted research over the first 2½ years of the Green House experience and we compared the results to the traditional nursing home on the same campus and a second traditional nursing home, also owned by Methodist Senior Services, located about 1½ hours away. At four points in time, each six months apart, we interviewed residents, family members, and all nurse's aide level staff at the Green Houses and the two comparison settings. We also compared results of the Minimum Data Set, a national assessment protocol conducted in all nursing homes, for the residents in the three settings.

I personally conducted many hours of observation in the Green Houses to see how residents, staff, and visitors used the physical space compared to their use of the traditional nursing homes.

We found that:

- Green House residents experienced a better quality-of-life on many dimensions of quality-of-life that we measured, and that they were more satisfied with the service in the nursing home and the place where they lived.
- Family members of Green House residents spent more time visiting residents, were more satisfied with the residents' care, and were more satisfied with how their own needs as family members were met—for example, they were better satisfied with their own communication with the nursing home.
- Compared to the nurses' aide level staff in the comparison nursing homes, resident assistants in the Green House had more intrinsic satisfaction with their jobs, were more likely to believe they had the ability to bring about better outcomes for residents on psychological and social dimensions, felt they knew the residents in their care better, and were more likely to remain in the job.
- Using the quality indicators measured nationally for all nursing homes, the results for Green House residents were as good as in the comparison settings and in a few cases were better. This is important because we wanted to be sure that no harm was done to quality of care with the greater freedom and quality-of-life experienced by Green House Residents.
- Elders in the two Green Houses that were dementia-specific functioned better in the Green Houses than in their previous stays in the locked dementia care unit.

We speculate that the Green Houses are successful because of the small scale, and emphasis on normal life and because of a model of care-giving that allows frontline staff and other staff to really know the residents.

The Green Houses are also successful because the physical settings, with their private rooms and inviting shared spaces, evoke a particular kind of behavior from residents and staff alike.

We are pleased that the Veterans Administration is considering developing similar small-house model nursing homes in the Veterans Administration Medical Center (VAMC) long-term care programs, including the nursing home care units (NHCUs) and long-stay units. The model should be adaptable to many VAMC campuses, particularly those where the NHCUs are older and are slated for rebuilding, and where land is available to build small-house style nursing homes. Although perhaps not in the direct scope of this committee, we also believe that this model is very suited to nursing homes in the State Veterans Homes that are operated by many State governments in partnership with the VA, and the local VAMC.

The Veterans Administration programs are characterized by a high degree of professionalism among staff members in nursing, social work and other fields, and have shown historic leadership in clinical geriatrics and geriatric team building. Some of the building blocks for a successful Green House project are, therefore, in place. A small-house nursing home program, such as the Green Houses, requires a high degree of leadership, skill, flexibility, and commitment from those who will serve as leaders, educators, and middle managers.

[The above-mentioned article from the *Journal of the American Geriatrics Society* follows:]

## Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program

Rosalie A. Kane, PhD,\* Terry Y. Lum, PhD,<sup>†</sup> Lois J. Cutler, PhD,\* Howard B. Degenholtz, PhD,<sup>‡</sup>  
and Tzy-Chyi Yu, MHA\*

**OBJECTIVES:** To determine the effects of a small-house nursing home model, THE GREEN HOUSE® (GH), on residents' reported outcomes and quality of care.

**DESIGN:** Two-year longitudinal quasi-experimental study comparing GH residents with residents at two comparison sites using data collected at baseline and three follow-up intervals.

**SETTING:** Four 10-person GHs, the sponsoring nursing home for those GHs, and a traditional nursing home with the same owner.

**PARTICIPANTS:** All residents in the GHs (40 at any time) at baseline and three 6-month follow-up intervals, and 40 randomly selected residents in each of the two comparison groups.

**INTERVENTION:** The GH alters the physical scale environment (small-scale, private rooms and bathrooms, residential kitchen, dining room, and hearth), the staffing model for professional and certified nursing assistants, and the philosophy of care.

**MEASUREMENTS:** Scales for 11 domains of resident quality of life, emotional well-being, satisfaction, self-reported health, and functional status were derived from interviews at four points in time. Quality of care was measured using indicators derived from Minimum Data Set assessments.

**RESULTS:** Controlling for baseline characteristics (age, sex, activities of daily living, date of admission, and proxy interview status), statistically significant differences in self-reported dimensions of quality of life favored the GHs over one or both comparison groups. The quality of care in the GHs at least equaled, and for change in functional status exceeded, the comparison nursing homes.

**CONCLUSION:** The GH is a promising model to improve quality of life for nursing home residents, with implications

for staff development and medical director roles. *J Am Geriatr Soc* 55:832-839, 2007.

**Key words:** nursing home; culture change; quality of life; longitudinal outcomes; quality indicators

After a critical 1986 Institute of Medicine report,<sup>1</sup> regulatory reform in nursing homes was launched, aimed at improved quality assessment, monitoring, and enforcement. A 2001 Institute of Medicine report noted improvements in overall health care but little reduction of societal dread of nursing homes<sup>2</sup> or improvement in quality of life.<sup>3</sup> The problems of maintaining a sense of well-being in a nursing home are well documented in decades of anthropological, ethnographic, and ethics studies.<sup>4-9</sup> Efforts to combat residents' learned helplessness with increased choices have resulted in measurable health benefits.<sup>10-14</sup>

A movement for culture change in nursing homes has gathered force since 1995, embracing transformed physical environments (e.g., smaller-scale, more-private rooms and baths and household-type neighborhoods for dining and occasionally cooking), transformed staff roles with more empowerment of line staff, and a philosophy of individualized care.<sup>15,16</sup> The "Eden Alternative," a set of principles overlaid on existing nursing homes to flatten hierarchies, invest decision-making in residents and frontline staff, and normalize nursing home life, addressed psychosocial problems of residents, such as loneliness, boredom, helplessness, and lack of meaning.<sup>17</sup> Eden training has been widely sought, but the few formal evaluations had unimpressive results,<sup>18,19</sup> suggesting that, without more-systemic changes in nursing homes, this model will have limited effects. In contrast, THE GREEN HOUSE® (GH) envisages a radically reconfigured nursing home.<sup>20</sup> The current study determines the effect of the GH on the quality of care in nursing homes and compares the quality of life of GH residents with that of those in conventional nursing homes. It was hypothesized that resident quality of life and satisfaction would be greater in the GH than in the comparison settings and that functional status and quality-of-care indicators

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would be at least equal to those of the conventional nursing homes.

## METHOD

### Design

The organization sponsoring the first GH to be implemented considered that randomization of residents to the GH was unfeasible, partly because money was initially raised to relocate the first 20 residents from a locked dementia care unit. Instead, the intervention was tested in a longitudinal quasi-experimental design. Two comparison settings were used: the sponsoring nursing home (Cedars) and another nursing home of the same nonprofit owner on a similar campus in a Mississippi community approximately 90 miles away (Trinity). Data came from in-person interviews with residents, family members, and line staff and from abstraction of the nursing home Minimum Data Set (MDS) for times preceding and most proximate to in-person data collection. (This first set of results reports data from and about residents and does not describe the methods and measures for studying family and staff outcomes.) The University of Minnesota institutional review board approved the study, informed consent was obtained for all primary data collec-

tion and chart reviews, and privacy requirements under the Health Insurance Portability and Accountability Act requirements were observed for using the MDS data.

The two comparison groups, Cedars and Trinity, each have strengths and limitations. The Cedars group was susceptible to contamination by having a shared administration with the GH and was potentially influenced by the GH planning and the ultimate goal of moving all residents to GHs; this could have led to spin-off improvements in the Cedars group or poorer results at Cedars because of neglect of the traditional nursing home and concentration on the GH. Although under the same ownership and experiencing similar local conditions, Trinity is a smaller nursing home with a subacute capability. The Trinity group represents the "natural history" of residents in a traditional nursing home setting in the same region and time period.

### Sample

Figure 1 displays the sample for each setting at each time period.

### Green House

The GH sample comprised the 40 people who were scheduled to move to the GHs at baseline and the current GH

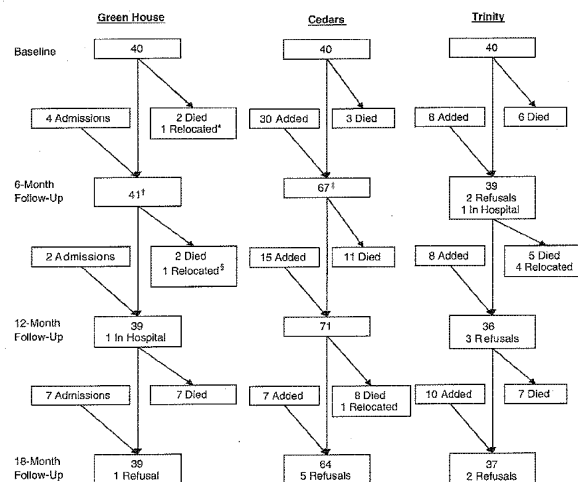


Figure 1. Sample sizes and disposition at each time point of data collection. Each box shows the number of completed interviews at each time point at each site. Additions to the sample at THE GREEN HOUSE® (GH) are due to new admissions; at any time, the total Green House capacity was 40. At Cedars and Trinity, subjects who died or relocated were replaced using random sampling within the respective facility to keep sample sizes stable. \*One resident who had relocated returned to Cedars at own and family request. <sup>1</sup>One resident was interviewed and died, and her replacement was also interviewed, accounting for the 41 subjects. <sup>5</sup>After baseline, Cedars was oversampled in an attempt to acquire baseline data from residents likely to enter GH at subsequent periods, resulting in larger numbers of subjects. <sup>6</sup>At 6 months, one GH resident was asked to leave and went to another nursing home. <sup>7</sup>The sample at Trinity dropped below 40 because, after exclusion of residents who were on Medicare and those who were comatose or vegetative, residents younger than 65 and those who refused, the eligible population was less than 40.

census at each of the three follow-up periods—6 months, 12 months, and 18 months. All told, 53 GH residents were eligible over the successive data collection periods, 52 of whom were in the sample. Ten of the GH sample members died over the 18-month period, and two were discharged.

#### Cedars

During the study period, the maximum census remaining at Cedars was 80. At baseline, a random sample of 40 residents was sought, excluding residents who were comatose, vegetative, or in end-stage palliative care; nine of the initial group approached declined to participate. In subsequent waves, to acquire as much baseline data as possible from residents who might later move to GHs, the Cedars sample was enlarged, with a goal of 70 per time period. The added sample members at all follow-up waves were randomly selected. The final Cedars sample sizes were 67, 71, and 64 for the three follow-up waves, with refusals from three, zero, and one person, respectively. The only live discharges from Cedars were to GHs, affecting six sample members; 22 of the Cedars sample died during the study period.

#### Trinity

Trinity had a capacity of 65 beds, 15 of which were in a Medicare unit. A sample of 40 residents was sought from the non-Medicare portion of Trinity, using the same exclusion criteria as at Cedars. The Trinity sample at the three follow-up waves was 39, 36, and 37, respectively. Sixty-six people participated from Trinity; 18 sample members died over the 18 months, and four were discharged alive.

#### Sample for Quality Indicators

The sample in all three settings for quality indicators (QIs) is larger than the sample for direct data collection. It comprised all those in the settings during each of three 6-month time periods, because it used MDS records for each setting.

#### Intervention

GHs are self-contained dwellings for seven to 10 residents needing nursing home levels of care. The physical environment is residential, offering residents opportunities for privacy (with private rooms and full bathrooms) and for community (with a residential-style kitchen where meals are prepared on site, communal dining tables, hearth areas, and accessible outdoor space). The GH avoids nurses' stations, medication carts, and public address systems. The frontline care staff members, who are certified nursing assistants (CNAs) assigned to a single GH, have broadened roles, including cooking, housekeeping, personal laundry, personal care to residents, implementation of care plans, and assisting residents to spend time according to their preferences. All professional personnel mandated in regulations (e.g., nurses, physicians, social workers, dietitian, pharmacist, therapy staff, and activity personnel) form visiting clinical support teams that provide specialized assessments and order and supervise care within their spheres of expertise. The CNAs report to an administrator (called a "guide") rather than to a nurse. Philosophically, the GH model emphasizes individual growth and development and a good quality of life under normal rather than therapeutic circumstances.<sup>20</sup> A group of GHs on a campus or scattered

in a residential neighborhood operates under a nursing home license and within a state's usual Medicaid reimbursement amounts, although a redistribution of expenditures could occur.

Four GHs were built on the campus of a nonprofit retirement complex comprising independent housing, assisted living, and a nursing home licensed for 140 beds. In June 2003, residents from the sponsoring nursing home occupied these GHs; two GHs were initially earmarked for residents in the locked dementia care unit (which was then closed), and residents from the general nursing home population occupied the others. The latter were filled from a list of residents voluntarily interested in moving, taken in order of the length of time that the residents had been on the campus. Residents already in the nursing home or on the campus similarly filled vacancies arising in the GHs after the initial move-in, again in order of length of time on the campus. A fuller description of the general model, its theoretical rationale, and its first implementation has been published.<sup>20</sup>

#### Data Collection

Data collectors (16 in total) from the local area received a 40-hour training at each wave. The resident protocol included administration of informed consent, a component administered to each resident (requiring about 45 minutes), and a component administered to staff about each resident's functioning. Interviewers physically visited all residents at each wave of data collection and turned to a family proxy only if residents could not be roused for an interview or could not respond coherently to successive questions. (The protocol for proxy use mirrored the procedures employed when the quality-of-life measures were developed and found reliable for persons with substantial dementia.<sup>21</sup>) Eligible proxy respondents must have visited the resident in the last month, and most were more intensively involved. Baseline data collection pertaining to the period before move-in to GHs began in May 2003. The 6-month follow-up began in December 2003, the next wave in May 2004, and the final wave in December 2004. Each data collection phase took approximately 6 weeks to complete.

#### Measures

##### Quality of Life

Eleven domains of quality of life were measured: physical comfort, functional competence, privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, spiritual well-being, security, and individuality. These domains scales comprised three to six items; each is standardized to a theoretical range of 4 to 1, by dividing the total score by the number of items. Most items used a 4-point ordinal scale (4 = often, 3 = sometimes, 2 = rarely, 1 = never); reverse coding was used for items so that a higher score always represented better quality of life. Those unable to respond to a Likert-type scale after three attempts (due to cognitive limitations) were asked the question with a "mostly yes" or "mostly no" choice. After empirical testing, these responses were extrapolated into the 4 to 1 scale, with a score of 3.8 for the affirmative and 1.5 for the negative responses. These measures have been tested in a large sample and have reliable scale properties, test-retest reliability, and concurrent

validity, and the domain scales have been shown to comprise separate but related measures of an underlying quality-of-life construct.<sup>21</sup>

#### *Health and Functioning*

Residents rated their health as excellent, very good, good, fair, or poor. Ability to perform activities of daily living (ADLs) "in the last few months" was measured according to self-report using five items: bathing, dressing, transferring from bed, using the toilet, and eating. Ability to perform instrumental activities of daily living (IADLs) was measured using six items: taking medicine, using the telephone, preparing food, light housekeeping, managing money, and doing laundry. For all ADL and IADL items, residents were asked whether they did the function by themselves, got a little help, got a lot of help, did not do it at all, or were not allowed to do the task; higher scores represented greater impairment.

#### *Satisfaction*

Global satisfaction was measured using three items: satisfaction with your nursing home as "a place to live," and as "a place to receive care" (both on a 4-point scale from very satisfied to very dissatisfied) and likelihood of recommending the setting to others (on a 4-point scale from very likely to very unlikely).

#### *Emotional Well-Being*

Emotional well-being was measured using an adaptation of a scale previously developed,<sup>22</sup> whereby residents were asked to rate how they had been feeling "lately" on 10 positive or negative emotional states: lonely, happy, bored, angry, worried, contented, sad, afraid, interested in things, and looking forward to the future; response choices were often, sometimes, rarely, and never. An additive scale with a range of 10 to 40 was developed by reverse coding the negative emotions; alpha reliability was 0.74.

#### *Other Variables*

Also included in the data set were sex, age, and time since admission (in months). For case-mix adjustment, ADLs (bed mobility, eating, transferring, and toileting) and cognitive functioning were extracted from the MDS and calculated using methods developed previously.<sup>23,24</sup> Social activity was measured according to self-reported frequency of participation in nine activities: leaving the grounds for organized activities, leaving the grounds for privately organized activities, staying away overnight, having an overnight guest in the nursing home, having a good conversation with any other resident, doing solo activities of personal interest, receiving visits from family or friends, and communicating by phone with family or friends.<sup>25</sup> The response set was every day, more than once a week, about weekly, less than weekly but more than once a month, about once a month, or not at all.

#### *Quality Indicators*

The 24 QIs were constructed from the MDS for residents in the GH, in Cedars, and in Trinity using assessments for the following time periods: between baseline and 6 months, between 6 and 12 months, and between 12 and 18 months after the GHs were operating. (Although Cedars and GH

were a single nursing home for federal MDS reporting, the data were separated for these analyses.) The QIs were constructed by adapting methods used previously<sup>26</sup> to include indicator-specific clinically derived adjusters as used in evaluations of quality of several managed care programs for elderly nursing home residents.<sup>27,28</sup>

#### *Data Analysis*

Stata version 9 was used for all data analyses (StataCorp., College Station, TX). Selection effects were examined by comparing baseline characteristics (independent and dependent variables) of the sampled residents who went to the GH, remained at Cedars, or were in Trinity. Outcomes were analyzed using multivariate panel regression analyses using the random-effects regression models; these used the data from the three follow-up periods over 18 months; baseline data were used only for case-mix adjustment. Wave of data collection was accounted for using dummy variables. The main independent variable was the resident's status as a GH, Cedars, or Trinity resident at the time of data collection. Data from the baseline interviews were used only to check for selection effects.

All analyses for self-reported outcomes were controlled for sex, age, time since admission, baseline ADL from the MDS assessment just before the subject entered the sample, and self-report versus proxy report. Because MDS cognitive function and proxy status were collinear, the analyses were run separately, adjusting for baseline MDS cognitive function, with almost identical results. The results that control for proxy status are therefore reported as more reflective of cognitive status at the exact time of the resident interviews.

The difference in residents' quality of life between the three nursing homes were analyzed using the random-effects Tobit model, chosen to take into account the nature of repeated measurements in this data set and floor and ceiling effects. Floor effects were absent in all quality-of-life domains except for autonomy (3%) and functional competence (17%). Ceiling effects were present in most domain scales, ranging from moderate (e.g., 24% for privacy and 32% for the food enjoyment subscale) to severe (e.g., 53% for dignity). Differences in self-reported health, satisfaction, and emotional well-being were studied using random-effects Ordered Probit regression models, chosen because the measures for these analyses were ordinal.<sup>29</sup> Differences in self-reported ADLs and IADLs were studied using random-effects population-averaged linear models. Testing was undertaken for possible interactions between proxy status and setting (Cedars, Trinity) in all models using a postestimation Wald test.

The differences in MDS QIs between GH and the other two nursing homes were examined using random-effects logit regression combining data from the three follow-up periods and including dummy variables for wave of data collection.

## RESULTS

### *Samples at Baseline*

Only two significant differences at baseline were found across the groups; residents remaining at Cedars had a significantly longer length of stay than those who went to

Table 1. Characteristics of Residents at Baseline

| Characteristic                                 | Green House* |         | Cedars            |                    | Trinity           |                    |
|------------------------------------------------|--------------|---------|-------------------|--------------------|-------------------|--------------------|
| Sample size, <i>n</i>                          | 40           |         | 40                |                    | 40                |                    |
| Female, %                                      | 80.0         |         | 87.5              |                    | 75.0              |                    |
| White, %                                       | 75.0         |         | 95.0 <sup>†</sup> |                    | 95.0 <sup>†</sup> |                    |
| Proxy, %                                       | 62.5         |         | 70                |                    | 50                |                    |
| Age, mean (SE)                                 | 81.4         | (10.4)  | 87.0              | (9.2) <sup>‡</sup> | 88.6              | (7.7) <sup>§</sup> |
| Days from admission, mean (SE)                 | 682.0        | (552.3) | 1,193             | (1,555)            | 1,108             | (988.0)            |
| Cognitive performance, mean (SE) <sup>  </sup> | 2.8          | (1.92)  | 3.7               | (1.4)              | 3.2               | (1.8)              |
| ADLs, mean (SE) <sup>  </sup>                  | 7.0          | (5.7)   | 8.6               | (5.8)              | 8.4               | (5.8)              |

\* Bivariate analyses used the Green House as the reference for tests of significance. One-way analysis of variance or chi-square tests were used depending on the type of variable.

† Significant difference from Green House:  $P = .006$ ;  $^{\ddagger} .008$ ;  $^{\S} .001$ .

|| Cognitive performance is measured from the Minimum Data Set; possible score range 0 to 6, with the higher scores reflecting more severe cognitive impairment.

† Ability to perform activities of daily living (ADLs) measured on a scale of 0 to 16, with higher scores reflecting greater impairment.

SE = standard error.

the GHs, and the GH had more African-American residents: 25% at baseline, compared with 5% at Trinity and Cedars (Table 1). The group who moved from the dementia special care unit accounted almost entirely for the difference in race; eight of those 20 residents were African American. No significant differences were found in age, sex, self-reported health, baseline ADLs, cognitive function, length of stay, or proxy status. No baseline differences were found in any of the 19 baseline outcomes measured (data available from author).

#### Effects on Resident Outcomes

##### Quality of Life

Table 2 shows the results of random-effects Tobit regressions of quality of life. GH residents reported better quality of life than Cedars residents on seven of the 11 quality of life subscales (privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, and individuality). GH residents reported higher quality of life than Trinity residents on four of the 11 measures (privacy, dignity, auton-

omy, and food enjoyment). GH residents did not report lower quality of life on any of the 11 measures than residents in Cedars or Trinity.

Table 3 shows the results of random-effects Ordered Probit regression on self-reported health, satisfaction, emotional well-being, functioning, and mobility. GH residents reported better emotional health than residents in Cedars. There was no statistically significant difference in self-reported health, ADLs, or IADLs across the three nursing homes. The results of the random-effects Ordered Probit regression on satisfaction showed that, GH residents reported significantly higher satisfaction with the nursing home as a place to live than residents of Cedars and Trinity and significantly higher satisfaction as a place to get care than residents of Cedars. They were also more likely to recommend the facility to others. GH residents had significantly better emotional well-being scores than Cedars residents.

The test for possible interactions between outcomes and proxy status revealed only one significant interaction. The use of proxy informants was associated with lower

Table 2. Effects of Green House on Quality-of-Life Scales

| Quality-of-Life Scale* | Cedars                                       |        |       | Trinity |        |       |
|------------------------|----------------------------------------------|--------|-------|---------|--------|-------|
|                        | Coefficient (Standard Error) <i>P</i> -value |        |       |         |        |       |
| Comfort                | -0.022                                       | (0.07) | .74   | 0.06    | (0.08) | .44   |
| Functional competence  | -0.122                                       | (0.18) | .48   | -0.09   | (0.19) | .62   |
| Privacy                | -0.818                                       | (0.12) | <.001 | -0.27   | (0.14) | .05   |
| Dignity                | -0.690                                       | (0.13) | <.001 | -0.56   | (0.15) | <.001 |
| Meaningful activity    | -0.261                                       | (0.08) | .003  | -0.07   | (0.10) | .79   |
| Relationship           | -0.353                                       | (0.11) | .002  | -0.08   | (0.13) | .51   |
| Autonomy               | -0.439                                       | (0.12) | <.001 | -0.27   | (0.14) | .05   |
| Food enjoyment         | -0.772                                       | (0.16) | <.001 | -0.65   | (0.18) | <.001 |
| Spiritual well-being   | -0.266                                       | (0.13) | .03   | 0.22    | (0.14) | .12   |
| Security               | -0.108                                       | (0.05) | .04   | 0.06    | (0.06) | .34   |
| Individuality          | -0.475                                       | (0.10) | <.001 | -0.16   | (0.12) | .17   |

Note: Random effects Tobit regression analyses with the Green House as reference group, controlled for sex, age, length of stay, proxy respondent in resident interview, baseline ability to perform activities of daily living (from the Minimum Data Set), and wave of data collection.

\* Each quality-of-life scale was standardized from 4 to 1, with higher scores representing better quality of life.

Table 3. Effects of Green House on Self-Reported Health, Satisfaction, and Functioning

| Outcome Measured                 | Cedars      |                  | Trinity     |                  | P-value |
|----------------------------------|-------------|------------------|-------------|------------------|---------|
|                                  | Coefficient | (Standard Error) | Coefficient | (Standard Error) |         |
| Self-reported health*            | -0.03       | (0.16)           | .86         | -0.17            | (0.18)  |
| Emotional well-being†            | -1.82       | (0.77)           | .01         | -1.68            | (0.89)  |
| Satisfaction with:‡              |             |                  |             |                  |         |
| Nursing home as a place to live  | -1.75       | (0.29)           | <.001       | -1.11            | (0.31)  |
| Nursing home as a place for care | -1.32       | (0.29)           | <.001       | -0.64            | (0.32)  |
| Would recommend to others§       | -1.45       | (0.27)           | <.001       | -0.67            | (0.29)  |
| ADLs                             | 0.42        | (0.44)           | .34         | -0.48            | (0.50)  |
| IADLs¶                           | 0.23        | (0.48)           | .63         | -0.25            | (0.54)  |

Note: Random-effects regression analyses with the Green House as reference group, controlled for sex, age, length of stay, proxy respondent in resident interview, baseline activities of daily living (ADLs) from Minimum Data Set, and wave of data collection.

\* A single item measured on a scale of 5 to 1, with 5 reflecting the best self-perceived health.

† Composite measure of 10 emotions, each measured on a scale of 1 to 4. The summed scale has a theoretical range of 10 to 40, with higher scores reflecting higher reported emotional well-being.

‡ Each of the two items was measured separately on a scale of 4 to 1, with 4 reflecting the greatest satisfaction.

§ Measured on a scale of 4 to 1, with 4 being the greatest likelihood of recommending.

|| Five ADL items, each measured with a 0 to 3 score, were summed for a theoretical range of 0 to 15, with higher scores reflecting greater ADL impairment.

¶ Six instrumental activity of daily living (IADL) items, each measured on a scale of 0 to 3, were summed for a theoretical range of 0-18, with higher scores reflecting greater IADL impairment.

meaningful activity scores for Cedars residents (-0.381 vs -0.201,  $P = .001$ ).

At baseline, no differences were found according to setting for any of the nine social activities measured. With the three follow-up samples combined and with the usual controls, the likelihood of participating in organized activities in the facility (e.g., games, performances, religious services) was greater at Cedars (coefficient 0.56,  $P = .002$ ) and Trinity (coefficient 0.65,  $P = .001$ ) than at the GH, but organized trips away from the setting were less likely at Cedars (coefficient -0.61,  $P = .001$ ) and even less likely at Trinity (coefficient -0.80,  $P < .001$ ). The GH group was just as likely to engage in solo activities, receive phone calls and visits, take privately arranged trips from the setting, or have an overnight guest as the comparison groups.

#### Effects on Quality of Care

Table 4 shows the effect of GH on MDS QIs relative to Cedars and Trinity. The GH had a lower prevalence of residents on bed rest, fewer residents with little or no activity, and lower incidence of decline in late-loss ADLs than Cedars. The GH had a lower prevalence of depression and lower incidence of decline in late-loss ADLs but a higher prevalence of incontinence than Trinity. Three of the 24 QIs could not be calculated because of sample size; there were no occurrences of new fractures in the GH or Trinity in the 18 months and four new fractures at Cedars, there was no dehydration in the GH and only one occurrence each at Trinity and Cedars, and there was no fecal impaction in any of the settings.

## DISCUSSION

### Summary

The results strongly favor the GH and suggest that it achieved its stated goals. GH residents had higher quality of life on nine of the 11 domains than did residents at Cedars

and on four domains than did residents at Trinity, were much more satisfied than residents in either comparison setting, and had better emotional well-being than residents at Cedars. On the QIs, the GH was superior to Cedars on three indicators and to Trinity on two. The GH had a lower incidence of decline in late-loss ADL functioning than either of the other two settings. The only difference favoring a comparison group for the 20 indicators that could be calculated was the higher rate of incontinence in the GH than at Trinity. On 16 indicators, GH performance equaled that of the comparison groups.

The finding that GH residents equaled the comparison groups in seven areas of social activity allays concerns that the GH model offers insufficient resident stimulation, because organized activities are underemphasized, and although GH residents were less likely to participate in organized activities, they were more likely than either comparison group to participate in organized social outings off the grounds. Furthermore, no reduction and some improvement was found in quality-of-life appraisals of meaningful activity and relationships.

### Limitations

The study could not be randomized, and although the samples were similar in important ways, they differed in age and race. They may also have differed in unmeasured ways related to selection for the GH, given that the initial fill-up of two GHs and all replacements were done from a list of residents who volunteered. The sample was small and entailed studying a moving target, because the intervention evolved during the period. Generalizability to other settings establishing a GH and to a GH implemented across an entire nursing home can be done only cautiously. Results might also be different if residents moved to a GH from their own homes rather than from a traditional nursing home. Given the simultaneous innovations, it was impossible to isolate how various parts of the intervention—

Table 4. Effects of Green House on Quality Indicators (QIs)

| QI                                                 | Cedars |                                                      |      | Trinity |            |     |
|----------------------------------------------------|--------|------------------------------------------------------|------|---------|------------|-----|
|                                                    |        | Odds Ratio $\pm$ Standard Deviation, <i>P</i> -value |      |         |            |     |
| Incidence of new fractures*                        | NA*    | NA                                                   | NA   | NA      | NA         | NA  |
| Prevalence of falls                                | 2.10   | $\pm 1.00$                                           | .12  | 2.04    | $\pm 1.11$ | .18 |
| Prevalence of behavioral symptoms                  | 0.51   | $\pm 0.25$                                           | .17  | 1.56    | $\pm 0.85$ | .41 |
| Prevalence of depression†                          | 0.97   | $\pm 0.39$                                           | .94  | 2.47    | $\pm 1.05$ | .03 |
| Prevalence depression without antidepressants      | 0.76   | $\pm 0.44$                                           | .64  | 1.72    | $\pm 1.02$ | .35 |
| Use of $\geq 9$ medications                        | 1.49   | $\pm 0.73$                                           | .41  | 0.88    | $\pm 0.47$ | .80 |
| Incidence of cognitive impairment                  | 1.42   | $\pm 1.47$                                           | .74  | 2.12    | $\pm 2.39$ | .50 |
| Prevalence of incontinence‡                        | 1.30   | $\pm 0.85$                                           | .68  | 0.21    | $\pm 0.16$ | .03 |
| Prevalence of incontinence without toilet plan§    | NA     | NA                                                   | NA   | NA      | NA         | NA  |
| Prevalence of indwelling catheters                 | 1.05   | $\pm 0.83$                                           | .95  | 2.48    | $\pm 2.09$ | .27 |
| Prevalence of fecal impaction*                     | NA     | NA                                                   | NA   | NA      | NA         | NA  |
| Prevalence of urinary tract infections             | 1.60   | $\pm 0.74$                                           | .31  | 2.44    | $\pm 1.17$ | .06 |
| Prevalence of weight loss                          | 0.84   | $\pm 0.27$                                           | .59  | 0.92    | $\pm 0.32$ | .80 |
| Prevalence of tube feeding                         | 1.15   | $\pm 0.75$                                           | .83  | 0.32    | $\pm 0.25$ | .14 |
| Prevalence of dehydration*                         | NA     | NA                                                   | NA   | NA      | NA         | NA  |
| Prevalence of bedfast residents‡                   | 3.70   | $\pm 2.10$                                           | .02  | 0.42    | $\pm 0.29$ | .21 |
| Incidence of decline of late loss of ADLs‡         | 3.01   | $\pm 1.52$                                           | .03  | 3.88    | $\pm 2.05$ | .01 |
| Incidence of decline of range of motion            | 1.80   | $\pm 1.01$                                           | .29  | 1.15    | $\pm 0.75$ | .82 |
| Prevalence of antipsychotic use—high risk          | 1.87   | $\pm 1.02$                                           | .25  | 0.41    | $\pm 0.27$ | .18 |
| Prevalence of anti-anxiety or hypnotic medications | 1.41   | $\pm 0.84$                                           | .56  | 2.42    | $\pm 1.52$ | .16 |
| Prevalence of hypnotic use $> 2$ times             | 1.65   | $\pm 1.25$                                           | .51  | 0.65    | $\pm 0.55$ | .61 |
| Prevalence of daily physical restraints            | 1.12   | $\pm 0.58$                                           | .83  | 0.75    | $\pm 0.43$ | .61 |
| Prevalence of little or no activity¶               | 5.01   | $\pm 2.68$                                           | .003 | 0.88    | $\pm 0.54$ | .83 |
| Prevalence of stage 1–4 pressure ulcer             | 1.18   | $\pm 0.66$                                           | .76  | 2.01    | $\pm 1.18$ | .24 |

Note: Differences in QIs were analyzed using random-effects logit regression models with the Green House as the reference group. Each QI was created with specific exclusions and adjustments, as applicable.<sup>27,28</sup> Specifications for all QIs are available from the authors; those with statistical significance are further in these notes.

\* Unable to calculate because of small sample size, low incidence of new fractures, and prevalence of dehydration or fecal QI in the settings. None of these adverse outcomes occurred at all in the Green House and rarely in the other settings for the samples during entire 18-month period.

† Adjusted for sex, age, cognitive performance score, cardiovascular accident, and Alzheimer's disease.

‡ Adjusted for comatose/vegetative state and end-stage disease.

§ Unable to calculate because of skewness; none of the eligible population with incontinence for this QI in all three settings had recorded toilet plans.

¶ Subjects totally dependent in activities of daily living (ADLs), comatose/vegetative, or without a prior ADL assessment were excluded. Adjustments were made for Cognitive Performance Score and Alzheimer's disease.

‡ Comatose/vegetative excluded. No adjustments.

NA = not applicable.

environments, scale, programming, staff arrangements, and philosophy—contributed to the results.

The sample was too small for an analysis of mortality. As GH replications increase, further research should examine mortality and hospitalization outcomes, perhaps using common datasets across GH projects.

Residents who entered the GH between waves were included in the study. The analytical models were repeated with dummy variables for the wave of entry to determine whether variable exposure to the GH was associated with differential outcomes. This analysis, available upon request, did not reveal any systematic differences in the effect of the GH on outcomes for residents who lived there for longer or shorter periods of time.

Staff were aware of being observed as part of an experiment. The risk of a Hawthorne effect here is greater because of the media, scholarly, and community attention lavished on the GH group and the lack of an "attention" intervention in the comparison settings. To partially test for this, the analyses were repeated using only the 30 individuals who had been in the GHs for the entire project period; it was determined that effects did not wane (analyses avail-

able on request). Nonetheless, in this real-world experiment, it cannot be discounted that a Hawthorne effect persisted through the whole study period, given that GH guides and even frontline personnel have been recognized as trainers for GH replications around the country. To the extent that a dramatically different work place and living environment results in sustained levels of enthusiasm among staff, residents, and families, the GH may be considered a success, but future replications should be studied in detail to determine whether "normalization" occurs and, if so, to what level of performance.

#### Implications

The GH entails sweeping and comprehensive changes, so much so that some proponents perceive it as the deinstitutionalization of a nursing home.<sup>20,30</sup> Many of the changes required abandoning orthodoxy—residents are in kitchens when meals are cooked despite hypothetical risks of infections, residents may be out of eye range of staff on patios or in their own rooms, maintenance therapy and activity tasks are largely done by frontline CNA-level staff rather than by

aides in the specialized departments of traditional nursing homes, the direct supervisory control of charge nurses is reduced.

Overall the positive differences between the GH and Cedars were greater than those between the GH and Trinity. This suggests that there were no positive spin-offs because of GH implementation on the campus, and reinforces the sponsor's view of the difficulties in operating a GH and a traditional model on the same campus. Indeed, based on its experience with the first four GHs, Cedars opened six more 12-person GHs. By November 2006, 112 residents were housed in 10 GHs, and the traditional facility was reduced to 28 beds, many used for a newly certified Medicare unit. In 2005, the Robert Wood Johnson Foundation began a replication project aimed at enabling 50 GHs to be opened in 5 years; projects participating in this initiative carry the trademark, GREEN HOUSE®. As the GH programs and similar small-house nursing homes proliferate, an accompanying research agenda is imperative. Future work should examine processes of implementation and management for sustaining the innovation. Inevitably, roles such as director of nursing or social work, activities staff, and in-service developer will change if nursing homes convert entirely to GHs, as will policies for admission and room transfer. Attending physicians and medical directors will be challenged to adapt their procedures so as to provide excellent chronic disease management in disaggregated nursing homes where CNA-level staff members, with whom physicians typically have less communication, are more central to the care and more empowered to monitor according to physician direction. Visits to GH residents are more likely to resemble a home-care visit than a nursing home visit. The GH also poses opportunities and challenges to providing posthospital recuperation, rehabilitation, and palliative care within GHs themselves.

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**Author Contributions:** All authors contributed to the study as part of a team, and the first four authors were intensively involved in the preparation of the manuscript. As principal investigator, Rosalie A. Kane had overall responsibility for study design and data collection and interpretation of results. Terry Y. Lum directed the statistical analysis and was involved in all phases of decision-making. Lois J. Cutler, coinvestigator, coordinated all phases of

fieldwork. Tzy-Chyi Yu served as research assistant, working closely with Dr. Lum.

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Senator WICKER. Thank you very much, Dr. Cutler. We're now going to move to Robert Jenkins, who is with us today from the Robert Wood Johnson Foundation, a group that I came to know as a State senator, when I was working on the Public Health and Welfare Committee in Jackson, and later as chairman of that committee. We appreciate the work of the Robert Wood Johnson Foundation.

The Green House Project's goal is to put a Green House in every State within 5 years. So we'll have an opportunity to hear about the lessons learned from Mr. Jenkins today. If you could, Mr. Jenkins, start off by telling us a little about the Robert Wood Johnson Foundation. Speak right into the microphone, if you don't mind. And then go from there to your prepared testimony.

**STATEMENT OF ROBERT JENKENS, MSRE, DIRECTOR, THE GREEN HOUSE PROJECT, VICE PRESIDENT, COMMUNITY SOLUTIONS GROUP**

Mr. JENKENS. Sure. Thank you, Senator. The Robert Wood Johnson Foundation is the funder for The National Green House Replication Initiative. The Robert Wood Johnson Foundation has provided funding to the nonprofit that I work for, NCB Capital Impact, to implement the program. And they have done that because they are the largest grant funder in health care in the United States. They are a foundation that was established initially by the man who started the Johnson & Johnson Pharmaceutical Company, and he had an enormous commitment to the health and health care of all Americans.

So, the foundation has worked for years in many areas of improving health care and health delivery systems. They have not worked in long-term care with skilled nursing care. They had worked to provide alternatives to skilled nursing care in the community, but they really felt that the system of nursing home care in the United States was, as Bill said, so deeply flawed and broken from its years of focusing on the medical model and the institution that they didn't believe that they would have an impact.

Last week, in a really very good *Wall Street Journal* article, the Foundation was on record for saying it was the Green House model—it was coming down to Tupelo and meeting Steve and seeing the enormous successes that Lois documents in her research—that convinced them that they could actually have an impact on long-term care; and changing it to be something that you or I would want to either have someone we loved or cared for in a Green House, or would ourselves be happy living in a Green House. And I think, as Steve said, the prayer that we all say to ourselves when walk into a typical nursing home doesn't happen in a Green House. And that's been a success. *The Wall Street Journal* article documents the Foundation's amazement that they have been able to partner with Steve and Bill and the others to create Green Houses around the United States to make a change that they didn't believe was possible up to 5 years ago. So, that is the reason for their involvement in this field.

We have been working with the Robert Wood Johnson Foundation at NCB Capital Impact for the last about 13 years on a variety of programs to improve long-term care for aging Americans, and

particularly, aging Americans with relatively low income and lack of access to the private health care that Steve mentioned that you can receive.

I am the director of The Green House Replication Initiative, which is the latest Robert Wood Johnson Foundation grant in this area. As you mentioned, the grant is a 5-year partnership. It is a partnership between Bill's Center for Growing and Becoming, the Robert Wood Johnson Foundation, and then, very importantly, the really pioneering providers like Steve McAlilly and Mississippi Methodist Senior Services who have taken an enormous risk. As Steve said, they didn't have Lois' research, but they believed in the concept, and they have made this happen.

The grant totals \$15 million, and that provides a variety of technical assistance and tools development, and that is a small revolving loan fund to help organizations create Green House programs. I'll focus my comments today on the successful implementation of the Green House model and how best to provide incentives and support to the Department of Veterans Affairs to include the Green House model among the many excellent culture change initiatives that they are working so hard on today to improve the care for our veterans.

Let me say first how proud I am of the greatly-enhanced quality-of-life and care outcomes that are being achieved in the Green House homes across the country, and to say how important it is that these are based on Dr. Bill Thomas' concept and the pioneering work of Steve McAlilly and his team at Mississippi Methodist Senior Services in Tupelo, Mississippi. We know from Dr. Cutler that these results show a very significant improvement in areas that we have worked for years and years in long-term care to improve, without success. And it is important that we take these successes forward, not as the only option, not as the predominant option, but as a choice among the others for all Americans, including our veterans.

The success of the Green House homes in Tupelo has inspired many others, and I am pleased to report today that there are 41 Green House homes open and operating across the United States. They are on 15 partners' campuses in 10 States. We have another 139 Green House homes in development on 19 campuses in an additional 12 States. So, in total, we're in almost half the States. You mentioned our goal is to be in all 50 States, and we think we are well on our way to doing that.

The dramatic improvements shown by Drs. Kane and Cutler's research indicate that, fully-implemented, the Green House homes can provide the improvements in the areas that Lois mentioned, including for our veterans. What I am particularly pleased about is that these improvements are in the areas that have been so hard to crack before, areas including privacy, dignity, autonomy, individuality, emotional well-being, meaningful relationships and activities, reductions in depression, reductions in induced dependence and incontinence.

Each of our operating Green Houses report similar improvements to the Tupelo Green House results. And next year we will start a broader research project to look and to document that these same improvements that Lois and Rosalie Kane found in Tupelo are able

to be replicated, that there wasn't something in Tupelo, maybe in the water or the creeks, that made this a distinct place where it won't happen again.

The outcomes, however, I think, are important to note. We need to have the full implementation. Bill talked about half of an aircraft carrier or a one-winged aircraft. And I do think it is important that it is understood that while, for instance, the self-managed work teams stand alone as a good idea, they support all of the outcomes and accomplishments of The Green House Project. And they are integrated in ways that are really very complex, and they can't be pulled out and segmented. So we do have people who come to us and say, we don't know about the self-managed work teams, or we don't know about the fully-detached houses. And I think it's important, as you all consider helping support and spread the Green House concept, that it is supported in a way that at least the core principles, which can be implemented very flexibly, are present in every Green House; or we will have lost the magic that has started in Tupelo. I can say that because I have worked on assisted living for many years as an advocate, especially for people with low incomes, to have access to high-quality assisted living. And that is a movement that started very pure and has been diluted over the last 15 years by people who used the name and applied half or a third of the concept. And the results in assisted living today are no better than what they would have been in a traditional board and care home or another model of care that has since been really discredited.

So, I would like to emphasize that The Green House Project, and helping veterans' homes adopt The Green House Project, really needs access to people like Steve and Bill and the technical assistance that the Robert Wood Johnson Foundation has sponsored. Because we have learned from each success of implementation and the importance of the different pieces coming together in a flexible way to support the individual needs of campuses across the country.

Let me stop there, and thank you very much for this opportunity to be part of the hearing.

[The prepared statement of Mr. Jenkins follows:]

PREPARED STATEMENT OF ROBERT JENKENS, MSRE, DIRECTOR, THE GREEN HOUSE® PROJECT, VICE PRESIDENT, COMMUNITY SOLUTIONS GROUP

Senator Wicker and Committee Staff, Thank you for this opportunity to provide my thoughts on The Green House® model and its potential role in caring for America's veterans.

My name is Robert Jenkins and I am the director of the national grant funded Green House® Replication Initiative. The Green House® Replication Initiative is a 5-year partnership between the not-for-profit I work for, NCB Capital Impact, The Center for Growing and Becoming (Dr. Bill Thomas' not-for-profit organization focused on culture change initiatives), and The Robert Wood Johnson Foundation. The Robert Wood Johnson Foundation has generously provided over \$15 million dollars to NCB Capital Impact to support development and replication of The Green House® model.

I will focus my comments on successful implementation of The Green House® model and how best to provide incentives and support to the Department of Veterans Affairs (VA) to include The Green House® model among the many excellent culture change initiatives they are working hard to make available to our veterans.

## GREEN HOUSE® OUTCOMES AND REPLICATION

Let me say first how proud I am of the greatly enhanced quality-of-life and care outcomes that are being achieved in Green House® homes across the country—each based on Dr. Bill Thomas’ concept and the pioneering work of Steve McAlilly and his team at Mississippi Methodist Senior Services in Tupelo, MS. The success of the Green House® homes in Tupelo, as documented by Drs. Kane and Cutler, has inspired many others. The Green House® Project currently has 41 homes operating on 15 partners’ campuses in 10 states. We have another 139 homes in development on 19 campuses in an additional 12 states.

The dramatic improvements shown in Drs. Kane and Cutler’s research indicate that, fully implemented, Green House® homes can provide significant improvements in the care and life of people who need skilled nursing care, including our Veterans. I am particularly excited that these improvements come in areas where we have struggled for years to improve outcomes, including a privacy, dignity, autonomy, individuality, emotional well-being, meaningful relationships and activities, depression, induced dependence, and incontinence. Each of our operating Green House® projects report similar improvements to the Tupelo Green House® results.

## OUTCOMES BASED ON FULL IMPLEMENTATION

It is important to note that the improvements documented by Drs. Kane and Cutler at Steve’s Tupelo Green House® homes rely on the full implementation of the core principles of the model set forth by Dr. Thomas in his book “What Are Old People For?” and documented in the current literature and requirements of The Green House® Project. This integrated model, carefully woven together in a web of mutual support, amplifies each element of the model to return outcomes greater than the sum of the parts and to defend against the return of institutional practices. The model is a whole that is greater than the sum of its parts and cannot be disaggregated or selectively applied with any certainty of approximating similar results.

## PRINCIPLES

The good news is that as a principles-based model, there is a fair amount of flexibility and creativity that may be applied to meet The Green House® principles, allowing model to address the individual needs and circumstances of many provider organizations. Key principles and elements of the model are:

*Philosophy*

Elders and persons with disabilities requiring skilled nursing care and living in a Green House® home are whole, capable, and distinct persons. As such they deserve:

1. A real home
2. True control over their lives, including schedule, activities, and care delivery
3. Dignity, including privacy, respect, and to be known as individuals
4. Meaningful lives, including the opportunity to give to others, form real relationships with staff and other residents, pursue their interests, and continue to participate in the larger community
5. High level and high quality services to allow them to age-in-place in the intentional community formed in a Green House® home

Direct care and clinical staff working in Green House® homes are talented, creative, and giving people working hard to care for our family members. They deserve:

6. Good jobs that are organized to use and recognize their full capacity, including problem solving and management skills
7. Meaningful days during which they provide and receive respect and services.

*Environment*

Creating a real home that supports control, dignity, meaningful days, and high level services requires a carefully designed house delivering the feeling of home, including great flexibility in schedule and personal preferences. At the same time, it must support extensive personal and clinical services, appropriate life safety, and strong defenses against institutional practices creeping back in to the lives of the elders and staff. To accomplish these goals, core principles and elements that are required in each Green House® home include:

1. Each home is a small, fully detached house or apartment (no more than 10 persons) designed, finished, and furnished in a manner that is consistent with the predominant residential program and design found in the immediate community.
2. All bedrooms are private occupancy, each with a private bath, and shared only at the request of the elder or person with a disability

3. An open plan “hearth” area consisting of a kitchen, dining area, and living room where elders, persons with disabilities, and staff may socialize, cook, and eat as they would in their own homes

4. Fully accessible, sheltered outside space available to people living in the home at all times

5. Support areas and features accessible to all elders and persons with a disability, including a den, office, spa room (with bath tub and hair wash sink), laundry, housekeeping/utility closet, storage, overhead lifts, and communication/sensing technology

6. A design and specifications meeting nursing home life safety standards required for persons unable to self evacuate

7. A complete absence of institutional elements that would not be found in your own home (e.g., a nurses station, call lights, public address systems, medication carts, commercial dishwashers)

#### *Organization*

The organizational design is critical in supporting control, dignity, and meaning in the lives of the people who live and work in Green House® homes. Key organizational elements are:

1. A self-managed work-team of direct care workers (“Shahbazim” in The Green House® Model) led by a “Guide” who is neither the director of nursing or simultaneously in a clinical role

2. A universal worker approach to tasks in The Green House®, including personal care, laundry, cleaning, cooking, and management task in the Shahbazim role

3. A coaching approach to leading the self-managed work team of Shahbazim

4. All food is cooked/prepared in the house according to menus selected by the elders and persons with disabilities living in the individual house

5. Flexible schedules for meals, awakening, bathing, etc. to meet the needs and preferences of the persons living and working in the homes

6. Capacity to provide the very high levels of care to allow aging-in-place

7. No institutional practices that interfere with a home environment or the control of the persons living in the home

#### SUCCESSFUL IMPLEMENTATION

In my experience at The Green House® Project, access to four things is critical to successfully implementing The Green House® concept:

1. Expert consulting on all elements of the model to support implementation, including project management, financial feasibility and models, regulatory assessment, design, financing, operational planning, policy and procedure development, start-up logistics, and post-opening problem solving and support

2. Experienced guidance for the process to assist each campus and implementation team with the principles and to challenge the team when, inevitably, institutional vestiges arise

3. Strong and detailed training on principles and their implementation, team and coaching skills, communication, and policies and procedures

4. A strong peer support network of providers who are operating and developing Green House® homes.

#### INCENTIVES

Christa Hojlo’s leadership at the Department of Veterans Affairs offers a significant incentive for individual VA campuses to consider using The Green House® model to enhance quality-of-life by building on their already strong clinical outcomes. However, cultural and organizational transformation is very difficult due to fear of the unknown and a lack of staff and capital resources. In this respect, the VA homes are very similar to most nursing homes in the United States.

The following additional incentives, successful in limited state applications, may help overcome these barriers with early VA adopters and get the movement rolling inside the VA.

1. Explicit expectations and timelines for improved quality-of-life outcomes

2. Opportunities for professional recognition for early adopters

3. Access to proven technical assistance resources and tools

4. Access to a high level VA/Green House® Project workgroup established to resolve internal and external issues that arise

5. Funding to support a dedicated team leader within the adopting VA organization

6. Assistance with construction and training costs

## RECOMMENDATION

I recommend the Committee craft a 5-pilot site demonstration incorporating these incentives to foster rapid replication within the VA. To assure outcomes equal to those documented at the Tupelo Green House® homes, I suggest that selected sites be required to fully implement The Green House® principles as determined by a workgroup composed of VA leadership, Bill Thomas, operating Green House® home staff, and myself.

Thank you for the opportunity to testify and your interest in The Green House® model. I welcome the opportunity to answer your questions.

[The above-mentioned article from the *Wall Street Journal* follows:]

PAGE ONE

**HOME REMEDY****Rising Challenger Takes On Elder-Care System**By LUCETTE LAGNADO  
June 24, 2008; Page A1

PRINCETON, N.J. -- In the spring of 2001, Bill Thomas, dressed in his usual sweat shirt and Birkenstock sandals, entered the buttoned-down halls of the Robert Wood Johnson Foundation. His message: Nursing homes need to be taken out of business. "It's time to turn out the lights," he declared.



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"Green Houses," smaller, home-like environments for seniors, are a growing alternative to larger, more clinical elder-care facilities. And while the Robert Wood Johnson Foundation is contributing millions to build more, obstacles remain. (June 24)

Cautious but intrigued, foundation executives handed Dr. Thomas a modest \$300,000 grant several months later. Now the country's fourth-largest philanthropy is throwing its considerable weight behind the 48-year-old physician's vision of "Green Houses," an eight-year-old movement to replace large nursing homes with small, homelike facilities for 10 to 12 residents. The foundation is hoping that through its support, Green Houses will soon be erected in all 50 states, up from the 41 Green Houses now in 10 states.

"We want to transform a broken system of care," says Jane Isaacs Lowe, who oversees the foundation's "Vulnerable Populations portfolio." "I don't want to be in a wheelchair in a hallway when I am 85."

The foundation's undertaking represents the most ambitious effort to date to turn a nice idea into a serious challenger to the nation's system of 16,000 nursing homes. To its proponents, Green Houses are nothing less than a revolution that could overthrow what they see as the rigid, impersonal, at times degrading life the elderly can experience at large institutions.

Susan Feeney, a spokesperson for the American Health Care Association, which represents thousands of for-profit and not-for-profit nursing homes, says the criticisms levied against the industry by Dr. Thomas and his supporters are "overly harsh." She says many nursing homes are embracing cultural changes to create a more homelike feel. "While it may not be scrapping a large building...we are changing," she says.

Green Houses face a host of hurdles. Many Green House builders say they've encountered a thicket of elder-care regulations. It takes enormous capital to build new homes from scratch. Plus, experts say the concept faces stiff resistance from many parts of the existing nursing-home system. Traditional nursing homes, many of which care for 100 to 200 patients, are predicated on economies of scale -- the larger the home, the cheaper it is to care for each individual resident.

**Bill Thomas**

Foundation officials acknowledge they don't know whether Green Houses are a viable economic model. But they've decided not to wait for an answer. Hewing to its recent strategy of making "big bets" on ideas to change social norms, Robert Wood Johnson is investing \$15 million over five years -- one of the bigger grants the institution has handed out to a single entity.

The foundation, which has \$10 billion in assets, is trying to encourage the building of Green Houses and is directing the cash to NCB Capital Impact, a Washington, D.C.-based not-for-profit that has been offering consulting, education, architectural and other help to any party interested in operating a Green House. The foundation is also studying the viability of Green Houses and says more support could follow.

"Robert Wood Johnson is making an important investment to try to make sure there is a sufficient cadre of early adopters of the Green House model -- and research to make sure the model is actually working," says Thomas Hamilton, who oversees nursing-home quality and regulatory issues for the Centers for Medicare & Medicaid Services. He says his agency is trying to coax

nursing homes into changing their cultures and adopting more humane, "patient-centered" models such as the Green House.

The \$122 billion nursing-home industry arose from the 1965 birth of Medicare and Medicaid, the government health-insurance programs for the elderly and poor that provide billions in government reimbursements. Made up of both not-for-profit and for-profit companies, the industry still generates most of its revenue from Medicaid and Medicare.

Now, many nursing homes are aging, and the industry has suffered through so many scandals involving patient care that many elderly shun the thought of entering such institutions. A 2003 survey by the AARP, an advocacy group for older Americans, found that just 1% of Americans over 50 with a disability wanted to move to a nursing home.

In recent years there have been attempts to create more popular alternatives, with mixed results. Assisted living, an ambitious effort begun in the 1980s to allow seniors to live independently in apartments and other group settings, has proved very popular but it "serves the needs of people who are relatively wealthy and relatively healthy," Dr. Thomas says. (Ms. Feeney of the American Health Care Association says the number of poor Medicaid elderly in assisted living is small but will grow.)

#### Avoided Issue

While Robert Wood Johnson has historically taken a substantial interest in issues affecting the elderly, for years it avoided funding nursing homes or even nursing-home reform. "Bluntly, trying to make change in a system that was uninterested in change didn't seem like a good investment," says Ms. Lowe.



Jane Lowe

Ms. Lowe and her foundation colleagues began to shift that stance after their meeting with Dr. Thomas. A native of upstate New York, Dr. Thomas headed to Massachusetts to get his degree at Harvard Medical School, then returned to work as a doctor in a local nursing home. He says he was troubled by the experience. "I was distressed by the amount of emotional suffering that people were encountering even when they had good medical care," he says.

Dr. Thomas spent years plumbing the issue, even penning a one-man play about a mythical land where elders were the heart of society. Further inspired by his two young daughters, both severely disabled and cared for at home, Dr. Thomas decided that changing nursing homes from within wouldn't be enough, and sat down "with a clean piece of paper" to re-imagine elder care.

Tall, sporting a beard and a mane of long, curly brown hair, Dr. Thomas showed up at Robert Wood Johnson's bucolic campus in 2001 attired in his usual casual garb -- he says he wasn't about to change his ways and decided he was "going there to rattle the cages." "This is a formal place," Ms. Lowe says. "In this organization, when someone comes in Birkenstocks and jeans and a hoodie you think, 'This must be the electrician.'"

But it was Dr. Thomas's electric delivery -- officials liken him to an evangelist -- that got the group's attention. "Our energy needs to be around how to replace nursing homes. Not replace the building but replace the idea that older people can be taken away and put into an institution," Dr. Thomas recalls saying. He described his vision of homelike places where elderly residents could gather, dine together and sit before a blazing fire.

Though she was taken aback by Dr. Thomas's attire, Ms. Lowe says she grew fascinated by his idea of a place where seniors could flourish and grow, yet still receive the same high level of skilled nursing care that nursing homes offer.

In 2003, Ms. Lowe traveled to Tupelo, Miss., where the first Green House had just opened, and says she marveled at how different it was from a well-regarded nursing home she'd previously visited. "Instead of thinking, 'I don't want to be here,' it was, 'How can I move in?'" she recalls.

Still, Ms. Lowe says the foundation deliberated mightily before making its move. Some still felt the system was too resistant for any change to happen.

#### Source of Resistance

One big source of resistance is the dizzying array of federal and state regulations that are mostly geared to protecting residents in large institutions. There are "life safety" rules intended to keep residents safe and prevent them from dying in fires and other disasters; "physical plant" standards that deal with building codes; health-care rules that guarantee a modicum of privacy -- requiring, for example, a curtain between beds. Infection-control regulations are meant to stop transmission of disease, while quality-of-life codes try to ensure residents receive adequate recreation and activities.

As a result, the groups with the know-how and resources to build Green Houses are often nursing-home operators themselves. Some nursing-home executives argue such rules can make it difficult, if not impossible, to create the homelike environment that is a Green House's hallmark. Generally licensed as nursing homes, Green Houses are designed to provide a full range of care to the very sick.

#### Fiscally Fit

Health is a leading area of foundation grant-making



#### Regulatory Hurdle

Late last year, Lynn Thompson, chief executive of the Mennonite Memorial Home in Bluffton, Ohio, says he wanted to build a couple of Green Houses in a cornfield near a residential neighborhood so seniors could live near families with young children. But because the Green Houses would be a mile away and on a different lot, Mr. Thompson says state regulators dictated they must be licensed as an independent nursing home, which meant they would have to have at

least 50 beds -- or build several more Green Houses. Mr. Thompson says it has put his plan at risk. "It has made it more expensive and more difficult," he says.

Rebecca Maust, chief of the Division of Quality Assurance at the Ohio Health Department, says in a statement that the agency "fully supports" person-centered care but that Green Houses have to be on the same lot as the main nursing home to "ensure proper care of residents."

Gerald Betters, who built two Green Houses near his traditional nursing home in Powers, Mich., created a regulatory backfash when he decided residents would help bake cookies. Mr. Betters says he found out residents would have to wear gloves when they help, a rule he feels undermines the effort to make the facility feel like a home.

When contacted by The Wall Street Journal, Catherine Hunter, a licensing officer for the Division of Nursing Home Monitoring in Michigan's Department of Community Health, said that her office had embarked on a "management review" and had found a loophole. The elders need only wash their hands, provided their hands are cut-free, Ms. Hunter said.

Mr. Hamilton of the Centers for Medicare & Medicaid Services says his agency doesn't think existing rules "represent any serious barriers" to the Green House model. He added that he wants to "maintain open lines of communication" to any parties who believe that a regulation is a barrier.

These operators may be the exception. According to Susan Reinhard, who heads the AARP's Public Policy Institute, some nursing-home owners aren't eager to switch horses. "You have owners who have their personal wealth invested in a model that was requested by society way back," she says.

"There are providers who don't want to change because of the capital investment they've made," adds Larry Minnix, CEO of the American Association of Homes and Services for the Aging, which represents not-for-profits. But he says they need to. "Forty years ago, the paradigm was the 'minihospital' and that is what became the modern American nursing home," Mr. Minnix says. "That is not what is needed now." Ms. Feeney of the American Health Care Association says the group is supportive of Green Houses.

Perhaps the most significant hurdle to Green Houses is the perception that they are too expensive. "The biggest criticism I hear is, 'How do you make it work financially?'" says Mr. Minnix, whose association represents not-for-profit nursing homes as well as assisted-living and retirement communities.

Jeffrey Shireman, president of the not-for-profit Lebanon Valley Brethren Home in Palmyra, Pa., says he worked with Pennsylvania's Health Department to build Green Houses at a cost of \$1.7 million a piece with open kitchens, comfortable couches and electric fireplaces (real fireplaces are a regulatory obstacle). "If I could afford to, I would abandon the other institutional units and build more Green Houses," says Mr. Shireman, who says his institution floated a bond issue and launched a capital campaign to fund construction of the Green Houses.

Michael Martin, vice president of Riverside Health System, which owns several traditional nursing homes as well as assisted living and other forms of elder care, says he was hoping to build some Green Houses and move 120 patients out of the traditional nursing-home beds his not-for-profit operates in Newport News, Va. He says the company even purchased land in nearby Williamsburg. But after intensive study, Mr. Martin says he concluded that Green Houses simply couldn't work financially.

Green Houses "will absolutely provide a quality of life unsurpassed," Mr. Martin says, but "they don't work financially without subsidy."

Others disagree. Robert Jenkins, who is spearheading the Green House project at NCB Capital for Robert Wood Johnson, says that some not-for-profits and at least one for-profit believe the model to be financially viable. St. John's Lutheran Ministries in Billings, Mont., operates both a nursing home and some Green Houses. In an internal review, officials found that it cost \$192 a day to care for a resident in the traditional nursing home versus \$150 a day in their Green Houses.

While building costs were high, Vice President David Trost says the Green House model also has cost savings. "We no longer have to take a resident 200 feet to the dining room -- we only have to take them 20 feet, and that is significant," he says.

Robert Wood Johnson executives say financial sustainability is a question they're scrutinizing intently. Based on this "first round" of Green Houses, they believe that it is financially doable, but they are rigorously testing the model and developing software that should help providers determine whether they can handle Green Houses financially.

Dr. Thomas says comparing Green Houses with nursing homes is an "apples-to-oranges comparison." "Green House belongs to the tradition of finding the better product, of building the better mousetrap," he says.

Write to Lucette Lagnado at [lucette.lagnado@wsj.com](mailto:lucette.lagnado@wsj.com)

Senator WICKER. Well, thank you very much Mr. Jenkins. Our final witness is Dr. Christa Hojlo. And as we said before, she is director of the VA Community Living Centers and State Veterans Home Clinical and Survey Oversight. Who pays your salary, Dr. Hojlo?

Ms. HOJLO. The Department of Veterans Affairs.

Senator WICKER. The Department of Veterans Affairs. OK. Well, we look forward to hearing your testimony today. We have already heard that—we have already heard some excellent compliments from Dr. Cutler about the VA and the professionalism of the staff working for our veterans. “The Veterans Administration programs are characterized by a high degree of professionalism among the staff members.” So, we’re glad to have that testimony as part of the record. But what can you add, and what can you tell the viewers, the audience today, as well as the Committee?

Ms. HOJLO. In order to do that, I would like to stay with my written testimony—

Senator WICKER. Yes, ma’am.

Ms. HOJLO [continuing]. Because I think it is important for the audience to understand the context of the services that we provide in our VA Community Living Centers. So, if I can do that, sir.

Senator WICKER. Absolutely.

Ms. HOJLO. Then, I certainly would be willing to answer some questions as we move forward.

**STATEMENT OF CHRISTA HOJLO, Ph.D., DIRECTOR, VA COMMUNITY LIVING CENTERS AND STATE VETERANS HOME CLINICAL AND SURVEY OVERSIGHT, OFFICE OF GERIATRICS AND EXTENDED CARE, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION**

Ms. HOJLO. First of all, I would like to thank you for hosting this hearing. I am truly honored—and your staff knows that—I am truly honored to be able to appear before you as a representative of the 13,000 community living center employees serving our Nation’s greatest and finest. I am proud to report that the Veterans Health Administration is following the lead of the innovators at this table by providing a dynamic array of services to veterans of all ages who require care in VA Community Living Centers.

The VA owns and operates 133 community living centers from Puerto Rico to Hawaii, with an average daily census of more than 11,000 veterans in fiscal year 2007. These facilities range from 20 beds to 240 beds, and we serve approximately 49,000 veterans annually with a budget of approximately \$2.7 million, and we do offer a dynamic array of services. This is an important concept—dynamic array of services. We have identified in the VA that some of our services are short-stay, similar to those covered under Medicare in the private sector; and then we also cover long-stay services. And the short-stay services, for example, are for veterans in need of rehabilitation or short-stay, post-hospital care, or short-stay for veterans awaiting placement someplace else in the community. And short stay is generally less than 90 days.

We also offer long-stay services for veterans with a disability rating of 70 percent or greater or who are in need of nursing home care for a service-connected condition requiring lifelong care. VA

Community Living Centers also offer respite care to any family members who care for veterans at home, and we offer hospice care in a kind and supportive environment so veterans may be with their loved ones and have the opportunity to live fully until they die with dignity.

Through its Community Living Centers, the VA provides care to veterans of all eras. And this is very important, because in the nursing home arena today, we often hear reference to elders. However, our members are not all considered elders. It is a very important concept for us. So, for example, we do offer care to veterans from World War II, from Korea, Vietnam, the Gulf War, and then the new cohort of veterans of Operation Enduring Freedom and Operation Iraqi Freedom.

Some veterans have short-stay needs, and others require longer stays, as I said earlier. Whatever their specific situation, we are there to help. We are sensitive to the fact that these different groups will have different expectations and different clinical needs. However, we are confident that the VA has the resources and the right strategy to address the interests of all veterans requiring care in these settings.

The term “nursing home” conveys certain impressions and ideas that do not reflect the VA’s approach to care. Informing a young, severely-injured veteran, for example, that he or she will need to live in a nursing home can be extremely distressing because the term often invokes stereotypical images of being cared for in a large institutionalized and geriatric setting. Consequently, we no longer use the term “nursing home” to refer to our facilities, rather, we refer to them as Community Living Centers. This terminology more accurately conveys the VA’s philosophy of care and commitment, and represents more than a name change.

This change in nomenclature is important because it emphasizes that the veterans residing in our facilities are unique individuals who have basic rights to privacy and autonomy that must be respected. The VA’s policies have evolved to clearly reflect and encourage the transformation in the culture of care. We are significantly improving work and care practices at existing VA facilities, and we are adjusting our designs for new centers as well as when renovations are in place.

Traditional nursing home designs have been centered on the needs of staff. The nurses’ station, for example, served as the central gathering place, and events are planned according to the staff’s calendar. In contrast, the VA’s approach is similar to the Green House or small-house model first developed here in Tupelo. We believe that our residents should be able to live as independently as possible. They decide when to have guests, when to eat, when to bathe and when to sleep.

Nursing care takes place in the veteran’s bedroom, not the patient’s room—a very important concept because the bedroom connotes an entirely different approach to personalized care than does the acute care model of a patient room, implying that the person is acutely ill and very sick.

[The prepared statement of Ms. Hojlo follows:]

PREPARED STATEMENT OF CHRISTA HOJLO, PH.D., DIRECTOR, VA COMMUNITY LIVING CENTERS AND STATE VETERANS HOME CLINICAL AND SURVEY OVERSIGHT, OFFICE OF GERIATRICS AND EXTENDED CARE, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Senator Wicker. My name is Dr. Christa Hojlo, and I am the Director of the Department of Veterans Affairs (VA) Community Living Centers (formerly VA nursing homes) and State Veterans Homes Clinical and Survey Oversight. First, I would like to thank Chairman Akaka and, you, Senator Wicker, for hosting this hearing. I am honored to appear before you as a representative of the 13,000 Community Living Center employees serving our Nation's bravest and finest, and I am in awe of our beautiful surroundings. We recognize and esteem the history made here at the Mississippi Methodist Senior Service facility on the grounds of the First United Methodist Church in Tupelo, Mississippi. I am proud to report the Veterans Health Administration (VHA) is following the lead of these innovators by providing a dynamic array of services to veterans of all ages requiring care in VA Community Living Centers.

VA owns and operates 133 Community Living Centers from Puerto Rico to Hawaii with an average daily census of more than 11,000 veterans in Fiscal Year (FY) 2007. These facilities range in size from 20 to 240 beds. We serve approximately 49,000 veterans annually with a budget of approximately \$2.7 billion and offer a dynamic array of services. "Short stay" services are for veterans in need of rehabilitation or skilled post-hospital nursing, or for those awaiting placement in a board and care home for a period of less than 90 days, generally. VA also offers "long stay" services for veterans with a disability rating of 70 percent or greater or who are in need of nursing home care for a service-connected condition requiring life-long care. VA Community Living Centers also offer respite care to relieve family members who care for veterans at home and we offer hospice care in a kind and supportive environment so veterans may be with their loved ones and live fully until they die with dignity.

Through its Community Living Centers, VA provides care to veterans of all eras—World War II, Korea, Vietnam, the Gulf War, and Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Some veterans have short-term needs and others require longer stays—whatever their specific situation, we are here to help. We are sensitive to the fact that these different groups will have different expectations and clinical needs. However, we are confident VA has the resources and the right strategy to address the interests of all veterans requiring care in these settings.

The term "nursing home" conveys certain impressions and ideas that do not reflect VA's approach to care. Informing a young, severely injured veteran that he or she will need to live in a nursing home can be extremely distressing because the term often invokes stereotypical images of being cared for in a large, institutionalized, and geriatric setting. Consequently, we no longer use the term "nursing home" to refer to our facilities—rather, we refer to them as Community Living Centers. This terminology more accurately conveys VA's philosophy of care and represents more than a name change.

This change in nomenclature is important because it emphasizes that the veterans residing in these facilities are unique individuals who have basic rights to privacy and autonomy that must be respected. VA's policies have evolved to clearly reflect and encourage this transformation in the culture of care. We are significantly improving work and care practices at existing VA facilities, and adjusting our designs for new centers as well.

Traditional nursing home designs centered on the needs of staff—the nurses' station served as the central gathering place, and events are planned according to the staff's calendar. In contrast, VA's approach is similar to the "Green House" or "Small House" model, first developed here in Tupelo. We believe our residents should be able to live as independently as possible. They decide when to have guests, when to eat, when to bathe, and when to sleep. Nursing care takes place in the veteran's bedroom. Our residents also choose what they want to eat, and food is served as if at home or in a restaurant. We respect the dignity of each of our veterans and try to simulate life as it might be in a private home.

VA is committed to a veteran-centric model of care and is developing formal guidance for its Community Living Centers with input from both residents and field staff. VA is the largest integrated health care system in the U.S. to adopt these principles, and we think there is even more we can do to provide a more personalized environment for our residents. Last month, VA held a conference for nurse and physician leaders in New Orleans to discuss this cultural transformation and to emphasize care for a new generation of veterans. A chairperson has been selected to

oversee the national training program and the planning committee will meet later this month to discuss next steps.

We are expanding age-appropriate care models in several ways in response to the needs of our residents. In some locations, we pair younger veterans with each other. At other facilities, the populations reflect several generations. Both models have their advantages. In an age-specific cohort, we can meet specific needs of younger veterans, who are more likely to have young children and similar interests, such as, computer technology and electronics, that differ from the interests of older veterans. In mixed-generation settings, our older residents can serve as parental surrogates for our young veterans. Meanwhile, interaction with younger veterans can provide older veterans with an important connection and a renewed sense of purpose. Inter-generational support is important for veterans of all ages.

Some of our facilities are geared specifically to younger veterans with cognitive deficits produced by the traumas of war, usually Traumatic Brain Injury (TBI) or Post Traumatic Stress Disorder (PTSD). For example, the Tuscaloosa Community Living Center has established a center and a TBI/PTSD program team for OEF/OIF veterans. VA's Community Living Center in Washington, DC, has separate living areas for OEF/OIF veterans. The National Defense Authorization Act for FY 2008 requires VA to provide age-appropriate nursing home care to veterans in need of such care for their service-connected disability and for veterans with service-connected disability rated at 70 percent or more. To fulfill this mandate, VA is developing proposals for future modifications to the environment of care in our facilities to further the goal of deinstitutionalizing nursing home care.

While we realize we can never completely match the experience of living in one's own home, VA is taking significant strides toward a more responsive and responsible model of care in a deinstitutionalized setting.

Thank you, Mr. Chairman, for the opportunity to appear before you today.

Senator WICKER. Dr. Hojlo, are those all private bedrooms, or are some of them—

Ms. HOJLO. Sir, because our facilities currently are very old, we still have a fair number of semiprivate rooms, and in some cases, three beds, which we are very consciously attempting to change. In our new construction, our new construction guidelines are very clear that we're committed to private rooms.

Senator WICKER. Thank you.

Ms. HOJLO. Our residents also choose what they want to eat, and the food is served as if at home or in a restaurant. Now, again, I just want to deviate here for a minute and say that this is a huge culture change for a system as large and as complex as ours, and we're actually beginning to serve, in some of our centers—we're moving away from a mess hall approach to dining, and personalizing. And we have some photographs of what folks are doing.

We respect the dignity of each of our veterans, and we try to simulate life as it might be in a private home. So we also are committed to home, not just home-like. The VA is committed to a veteran-centered model of care, and we are developing formal guidance for our Community Living Centers, with input both from residents and field staff. And again, I want to deviate from the formal testimony for a minute to say that we are in the process of finalizing some official guidance national policies. And for the first time in our history, this set of national policies, which hopes to be signed on fairly soon, is written from the veteran's perspective. In other words, the policies are typically written by me, in my office, and we have engaged field staff in writing this policy and we have engaged field staff to incorporate veterans' thinking. And we have used the Resident Bill of Rights as the foundation for the document. And again, this emphasizes the person-centered approach to care.

Senator WICKER. Can I go online and find that Bill of Rights?

Ms. HOJLO. The Patient's Bill of Rights, I believe so—the associated Medicaid services. It is a standard bill of rights, yes.

The VA is the largest integrated health care delivery system in the United States. To adopt these principles—and we think that there is even more that we can do to provide a more personalized environment for our residents. Last month, the VA held a conference for nurse and physician leaders in New Orleans to discuss this culture transformation and to emphasize care for a new generation of veterans.

A chairperson has been selected to oversee a national training program, and a planning committee will meet later this month to discuss the next steps, particularly so that as we design our culture transformation and the approach to care, that we recognize the fact that we are receiving a new cohort of veterans. And we're expanding our age-appropriate care models in several ways in response to the needs of all of our residents.

In some locations, we pair young veterans with each other, in our current models. At other facilities, the populations reflect several generations. Both models have their advantages. In an age-specific cohort, we can meet specific needs of younger veterans who are more likely to have young children and similar interests, such as computer technology and electronics, that differ from the interests of older veterans.

In mixed-generational settings, however, our older residents can serve as parental surrogates for our young veterans. For example, what we're seeing in the cohorts of veterans that we have, we see the young son of the Vietnam era vets are very often, for example, equivalent to what the young vets would see in their dad's age, and then we have the grandparents.

And in reflecting on that model, we find that, although the generational differences may be significant, they all have one thing in common: they have served our country. And that has created a buddy system and opportunity for these veterans of different cohorts to actually—for example, when you have a young man or woman with TBI, a brain injury, who is cohorted with some older veterans, the older veterans actually tend to look out for that young person. It is quite awe-inspiring to see the bonding that occurs. So this is to dispel the fact that young people may not do well in an old folks home. When there is a mixing of generations with a consciousness toward what that intergenerational activity could really accomplish, the outcomes are quite touching and quite profound.

Senator WICKER. How large of a group are you talking about?

Ms. HOJLO. For the Iraqi—

Senator WICKER. In this context, you mentioned the settings. How many people are in a setting?

Ms. HOJLO. It varies across the country. In the new models, as we're trying to reflect on small house and Green House models, we're speaking of about 8 to 10. And we have not had the opportunity yet to build those structures. Currently, our individual nursing home neighborhoods or communities range anywhere from 22 to 30 units. And within those units, we can cohort veterans as well. So it really differs across the country, based on what the popu-

lation needs are, what the individual veteran's needs are. And our structures also limit—

Senator WICKER. So those are the smallest settings—those are the smallest groups now in a setting?

Ms. HOJLO. Right.

Senator WICKER. Is the VA actually looking at trying this 10 or 12 and below setting and actually experimenting with that?

Ms. HOJLO. Absolutely, sir.

Senator WICKER. When do you think we might be able to break ground on the first one of those?

Ms. HOJLO. We have, actually—we're working with the National Defense Authorization Act, and we have submitted a budget for several Green Houses within the context of that act. So we're actually having some conversations with Mr. Jenkins. Some of our facilities have engaged in conversations with Mr. Jenkins. We have established a design guide that is actually affirming this direction. I am sorry, I cannot give you an exact date, but I can tell you that there is a strong commitment to moving in this direction, especially in new facilities.

We have an example that I brought here of our facility in Biloxi. It isn't quite Green House, but it is very close to cohorting veterans in a smaller setting. So this is actually a first.

Senator WICKER. Are those the pictures that—

Ms. HOJLO. Yes. I will go through them. All of the pictures don't reflect Biloxi, but Biloxi's model is in the drawings that we have.

Senator WICKER. OK. I am going to go ahead and pass these through the audience. We have only one copy—two copies. We will start one in the back and one in the front. OK, go ahead. Are you almost finished?

Ms. HOJLO. Yes, sir, I am. Some of our facilities are geared specifically to younger veterans with cognitive deficits produced by the trauma of war, usually a Traumatic Brain Injury or Post Traumatic Stress Disorder. And I would like to highlight our Tuscaloosa Community Living Center has established a center with a TBI and PTSD program team for young veterans returning from Iraq and Afghanistan. The VA's Community Living Center in Washington, DC, has separate living areas for these veterans. As I have said, the National Defense Authorization Act requires the VA to provide age-appropriate nursing home care to veterans in need of these services. To fulfill this mandate, the VA is developing proposals for future modifications to the environment of caregiving in our facilities to further the goal of the institutionalized nursing home.

So, even though we don't have a Green House at the moment, we have developed some policies, again, that were recently signed off that gives specific guidance of how veterans coming into the VA nursing homes, particularly the younger veterans, would require definitely a home-like, personalized environment for actually the home setting, even in the context of some of our old facilities. And it is amazing. You'll see by the photographs what we have been able to accomplish, even in some of the current facilities.

We realize we can never completely match the experience of living in one's own home. The VA is taking significant strides toward a more responsive and responsible model of care in a de-institutionalized setting.

I thank you for the opportunity to appear before you today, and ask if you would like me to go through the slides?

Senator WICKER. Well, let me ask you, I think we'll try to—it's 11:44. We're going to try to wind up in 30 minutes. That will get us out of here by 12:15, if that's OK. So, let me proceed on without that. But I do very much appreciate it.

Let me just ask you in follow-up, there are VA settings, and you have changed the name, and you say that it is not only a name change, it is actually a change in mindset. What interaction at all do you have—and you can answer briefly—with the DOD retirement homes?

Ms. HOJLO. Directly, in my position, I don't have any direct working relationship with the DOD. However, through the National Defense Authorization Act, as we design these principles, that act does require some type of interaction between the DOD and the VA. However, the clarity of that interaction and relationship to the nursing homes or Community Living Centers isn't there. So I certainly would be happy to interface with them. However—

Senator WICKER. Here's why I ask—go ahead. I don't want to cut you off.

Ms. HOJLO. The concept of culture transformation is really very new. And in some ways we feel that we need to establish what it means for us, the VA. And in a way, it is "take care of your own house" and then move it to someplace else.

Senator WICKER. Sure. I am just wondering if you shared data or concepts or research. Here's what I'm getting to. We had a very interesting meeting with DOD representatives of the Armed Forces retirement homes, and basically they said the veteran is different, has a different desire for long-term health care. They loved the mess hall setting. They are used to it on the ship or in the mess hall. And so breaking it down into a 12- or 10-person home-like setting is not the way to go. I just wondered if you had found that to be the case in dealing with veterans yet in another agency? And then I'll let others respond to that question.

Ms. HOJLO. Thank you for that question. I believe that we don't really have enough information in the Department of Veterans Affairs to be able to make a judgment either way, again, because all of this is so brand new. And as we develop the Green House model, and as we move the cultural transformation forward, we are intending to obtain data and do some research in that area. So, I personally am convinced that that's a great opportunity. And what we are doing in our current settings is we are moving away from the mess hall model. You see photographs where we have white tablecloths with a smaller number of veterans. And, anecdotally, veterans seem pleased with that. We're making the atmosphere in the dining rooms quieter. We are not providing medications or treatments during that time, as we did in the past. People would come in and do blood pressure checks and maybe provide insulin or medications during mealtime. We don't do those things anymore. So we're trying to humanize and de-institutionalize the way food is served, but we don't have enough data yet.

Senator WICKER. All right. Well, I am going to let other members of the panel address that question. Let me mention this *Wall Street*

*Journal* article which is already a part of our testimony, and that also will be made a part of the permanent record. It is dated June 24, 2008, by Lucette Lagnado of *The Wall Street Journal*. And, basically, let's start with you, Dr. Thomas. Susan Feeney, of the American Health Care Association, visits thousands of for-profit and not-for-profit nursing homes and says that you're being overly harsh, that many of the traditional nursing homes aren't able to scrap a large building, but they are changing and making reforms and changing the culture to a more home-like feel. Are you being a little unfair to the thousands and thousands of traditional nursing homes? Would you respond to that?

Dr. THOMAS. I would love to, thank you. First off, I'll tell you a distinction that I use in my work that is very helpful to me. There are the tens of thousands, hundreds of thousands of dedicated nurses, doctors, caregivers, speech therapists who, every day in America, do the hard work of providing long-term care. These are flesh and blood human beings, and I honor them entirely.

Senator WICKER. In a variety of settings.

Dr. THOMAS. Oh, yes. Then there is the institutional pattern of long-term care. The institutional mindset that puts tasks ahead of people, the institutional architecture, the nonprivate room, with a sheet hanging between two beds. I do not honor that. I reject that. I say that it is time to move forward. And I would like to make it really clear that the harshness of my criticism—and, yeah, I'll use harsh language—is directed at the system we have created.

What I have found—and I know Dr. Hojlo shares this with me over a long period of time—is that efforts to change the system are very difficult; that I have found in my work and research that making small changes to an institutional long-term care setting is not only hard to do; it is hard to make the changes stick. That is why—and Steve and I share this view—that I have moved toward a more transformational approach that says it is time to put an end to the warehousing and institutionalization of our elders. And that requires us to develop and test, research and improve new models. That's really where I am coming from, and that is where Green House is coming from. And honestly, if the chief lobbyist for the nursing home industry says I am being too harsh, then I am probably doing my job.

Senator WICKER. Is Mr. McAlilly warehousing elderly people in this traditional nursing home facility?

Dr. THOMAS. Yes. And it is not Steve's fault, and it is not the fault of the people who go to work there every day and give their hearts to that work. It is not their fault. It is a pattern, a system that does not provide the kind of dignity and autonomy that our elders deserve.

Senator WICKER. Is there data on the other side of this question?

Dr. THOMAS. Dr. Cutler would be the one to really talk about this, but I'll tell you this: The funny thing is there is really no—I am going to say, Dr. Cutler, you disagree with me, if you can—there is no research that shows that institutional long-term care is the best model.

Senator WICKER. OK. He has tossed it to you, Dr. Cutler.

Ms. CUTLER. He is correct. Fortunately, in the last several years we have been even breaking down studying the institutional model

to private rooms, the benefits of private rooms—and one thing I think—one thing I do like about the Green House model, and what we try to do in any nursing home, traditional or not, that we go into is to subdivide the institution, the Green House, into three categories. You have your physical environment, of course, which is very easy to model or to measure. You have got your organizational patterns, and that is where the Green Houses went totally topsy-turvy. And then you have your philosophy of care, which is much more difficult to measure.

I think it kind of makes me—number one, I am not fond of the word “culture change,” but it kind of makes me a crazy lady that now we’re, all of a sudden, concerned with person-centered care. And I keep thinking, OK, over the last 40 or 50 years, who were you centering the care on? So, I do digress from your question.

Dr. Thomas is correct; there is not a lot of research, probably—well, I won’t even add that. But there is not a lot of research on contentment in the traditional nursing home.

Senator WICKER. I see. Mr. McAlilly, are these facilities in Tupelo coed?

Mr. MCALILLY. Yes.

Senator WICKER. And how are they selected? Are they intentionally coed, or does it just work out that way?

Mr. MCALILLY. It just works out that way. We try to make the population in each Green House as diverse as we can make it.

Senator WICKER. OK.

Mr. MCALILLY. We think diversity is healthy.

Senator WICKER. Now, what if you want to visit some friends two houses down?

Mr. MCALILLY. You go visit them.

Senator WICKER. Does that happen?

Mr. MCALILLY. It happens.

Senator WICKER. So it’s not that you’re just locked into these 12 people forever?

Mr. MCALILLY. No. And that becomes—you know, there is not a traditional activities program in a Green House. What the activity is, is living. So, if you used to visit neighbors in your neighborhood, you have friends two houses down, you go visit them. We know, either—if a person needs assistance to get down there, we provide that. But it is not like a self-contained prison that you can’t get out of. It is a neighborhood.

Senator WICKER. I bet this question is in the minds of those in the audience. Is this something that we can afford? Now, I know, Mr. McAlilly, you say that you offer the care at the Medicaid rate, and yet Methodist Senior Services is a well-endowed charitable organization that is supported by many people of good will all over the State and all over the Nation. If it weren’t for that, would you be able to offer care at the Medicaid rate? And are we talking about something that would be desirable for everyone, but simply at a time of deficits and the skyrocketing cost of health care, we really can’t afford at the Federal level?

I’ll ask each member of the panel answer that question. What about the cost, and can we afford this concept that sounds very, very desirable?

Mr. MCALILLY. I believe, absolutely, you can afford it. And the reason for that is our operations are strictly based on the income that we receive through Medicaid, Medicare or private pay residents. The operations are not subsidized by charitable giving in the Green Houses, except for on the front-end in the up front capital of building the building. We did have charitable donations there so we could afford the debt service of payment on the Green Houses. We made a commitment early on. We knew that we were going to spend more money, because we were going from semiprivate rooms to private rooms. But the outright operations on a day-in and day-out basis can be done at the current funding levels that, I think, pretty much everyone receives across the country.

Senator WICKER. Mr. Jenkins, you're scribbling notes.

Mr. JENKENS. I am. Thank you, Senator.

Senator WICKER. I think this really gets to the heart of what the Committee will need to know, and that is, is this something that actually can be afforded on a large scale by the Federal Government?

Mr. JENKENS. Yes. There are, I think, three areas that are important to consider with that question. The first is that there is a significant body of research which shows that improvements—significant and meaningful improvements—in quality in nursing homes does result in lower operating costs, to the extent that we, as a government and a society, reimburse based on operating costs, which we do in many States through the Medicaid program. That would offer some potential for cost reductions. *The Wall Street Journal* article that you mentioned quotes one of our Green House providers in Billings, Montana, that when you compare their operations in a Green House to their operations in the remaining skilled nursing home, that they are about \$42 a day less in operating costs in the Green House.

Now, in the beginning, they were a little bit more. And there is a typical transition that people go through as their operations settle in, but we're beginning to hear anecdotally that same comment from others. We shift costs from administrative functions and middle management into direct-care staff. So, we significantly increase the direct-care staff, but we believe there are savings from the operational redesign as well as the improvement in quality.

Research has also shown that having about 4 hours of direct care time per day, which is what the Green House mandates, at a minimum, is one of the surest ways to improve your quality outcome. So, the model in building design, as Steve has implemented in Tupelo, is really designed very carefully to look at how do you get the best of our research, the best of our understanding in there. It is a nice combination, but it actually turns out to help reduce cost because of higher quality.

Important from the Federal level is that—and research that we will start next year should show what we have heard anecdotally—is that the Green House also—because people know each other better and nurses and physicians can treat people better with better information from the shabhazi—that you are seeing fewer hospitalizations. Our project in Lincoln, Nebraska, reports their Green House elders, compared to their elders remaining in the traditional setting, had fewer acute illnesses, fewer hospitalizations. That

doesn't translate into savings to Medicaid, but it does translate into savings to Medicare. So, at the Federal level, it is very meaningful to have a foundation of homes, like the Green House, to offer a combined savings to the Medicaid/Medicare program.

Steve mentioned the capital costs, and the capital costs—if you were to build any new nursing home, you would face capital costs. We don't fund capital costs through the Medicaid system. We have caps for development costs, which are generally at about half of what it truly costs someone like Steve to build a Green House home. So, the one area where the Federal Government may want to look at expenditures that would be different from what you would have in a typical nursing home setting is around the capital, in order to capture some of these long-term operating savings, which will quickly outpace any capital costs.

Senator WICKER. Anyone else want to jump into that?

Dr. THOMAS. I would like to say one thing.

Senator WICKER. Dr. Thomas?

Dr. THOMAS. I think that Dr. Hojlo and the Veterans Affairs group is really very ideally positioned to actually use these kinds of new models to increase quality and create savings. Because what they have, which a lot of us, for example, Steve, doesn't have, is a really integrated system of health care at work. And in Steve's case, he can save Medicare a lot of money, but it doesn't save Steve any money—you know, his organization. And the VA has the opportunity to drive quality to higher levels, generate savings, which go to the system and allow them to provide even better service for the veterans.

Ms. HOJLO. Would you like me to comment, sir?

Senator WICKER. Yes, please, ma'am.

Ms. HOJLO. Thank you. There are several pieces in this that I think are important to be looked at. I would like to just comment about what we talked about earlier about the warehouse model. Prior to the culture transformation movement—and I will speak about this in terms of VA—we simply—somebody in acute care wrote an order and said, “nursing home care.” So what my office did was we said, what does nursing home care mean? Well, we recognize that, first of all, nursing home care truly does offer—it is a set of services. So you have to be clear on why is the person going to a nursing home and not going home? So we actually articulate what those services might look like.

Now, Medicare has a defined set of services, and Medicaid has the longer term. However, even within those categories, there are specific reasons why people have to go to nursing homes. And we recognize that. So that, in itself, first of all, has cost implications, because we no longer say, well, just go to the nursing home and figure out what he or she needs—a very, very important piece of this.

Second, there is ample research on the fact that, you know, when folks don't have attention to incontinence, falls, those kinds of things, and they don't have meaningful use of time, then we increase psychotropic medication use. Costs of care significantly increase because of falls and those kinds of things. So settings and mindsets that provide care delivery in a manner in which you do pay attention to the individualized needs for care. Consistent staff-

ing, for example, is very, very important—that the same nursing personnel take care of that same veteran so they protect that person. They know what this person’s likes, dislikes, and needs are, so you can anticipate them, therefore preventing falls and——

Senator WICKER. And the veteran has a comfort level.

Ms. HOJLO. Exactly, the veteran has—so the quality-of-life improves. And we know, as the quality-of-life improves, the veterans’ outcomes improve. And finally, the notion of meaningful use of time—having something to do all day, not just Bible, Bingo and birthdays, but actually planning the day around who is this person? We’re even changing our approach to care planning. We use the new methodology called I Care Plans, meaning that I, as a care provider, put myself in the shoes of that veteran and not talk about their diagnosis, but plan the care around who is this person who happens to have Alzheimer’s, or who is this person who has had a stroke?

So, all of those things, I believe, contribute to improved outcomes and hopefully, cost reduction. However, we really don’t have enough data. We don’t have research yet to document that. This is all very new. And our intent in the VA is that, as we develop and evolve these models, that we will, in fact, contribute to the very important evidence base to make this movement go forward.

Senator WICKER. In terms of the progress that we’re making in the VA toward advancing the Green House concept, Dr. Thomas and Mr. Jenkins, I think the testimony from Dr. Hojlo is that there is language in the current DOD authorization bill that will authorize an experiment in the Green House concept. And I know that you, Dr. Thomas, are completely sold on the concept for every single elderly American. But is the language in that bill—you have looked at the language, and is it sufficient to get us to where we need to be in terms of an honest-to-goodness experiment on the ground to see if this will work?

Dr. THOMAS. Actually, I would like Mr. Jenkins to start, and then I will pick up on that. Because we actually were meeting and talking about that this morning.

Mr. JENKENS. Thanks, Bill. First, I would like to recognize Dr. Hojlo for what I think has really been exceptional leadership within the Department of Veterans Affairs around this issue, not just with the Green House, but with culture change and the people that she works with who support her. It takes a courageous person to do this. Steve spearheaded this in the nursing home industry. And I think Dr. Hojlo is doing that with the VA.

Senator WICKER. Particularly courageous to scrap thousands of dollars worth of design and plans when you have a board looking at you.

Mr. JENKENS. It is. I think that is very true. I think that there are a couple of things, in looking at how to move forward and understand whether it works for the VA, particularly. I think pilot sites are very worthwhile. I would recommend a few more pilot sites than two, because I think there is such variety and diversity within the VA system that you might want to start with a slightly larger number around this.

I think you would also want to add to that an initiative—a work group between people like Steve, who have done this, and Bill—

people who are providing technical assistance at a national level. Because I think one of the challenges that Dr. Hojlo and her team face are, how can a model be translated effectively into the VA system without losing its core benefits, but with not being able to understand exactly how those pieces all play into the results? Bill mentioned that we don't know exactly what it is with this whole model that delivers any piece of the results. I think Dr. Cutler would agree that we haven't disaggregated the research enough to know that. So, I think the only way we can do that effectively is to talk to each other and make our best educated guesses, based on what we have seen. I think a work group, as part of that initiative, would be a very healthy addition.

Then, of course, providing incentives is very important so that Dr. Hojlo and her team don't have to carry all of the weight and make all of the errors or changes. That can be very difficult; and many people can be very opposed to education performance indicators or other measures that would help people be inspired to do this.

Senator WICKER. OK. Thank you. We're nearing the end of our allotted time, and I appreciate everyone participating. Let me say I will call on each one of you, if you want to sum it up or make a final statement, say, 1 minute each.

Before that, I had asked Susan Sweat, on my staff, to give me a list of the staff members here, and in all humility, she did not provide me the names of my own staff. So, let me particularly single out Susan Sweat for her hard work. She is part of my Washington, DC, staff and did a great deal of work. She has been a very effective staffer for you, the taxpayers, in this area of health care; and is now my legislative director. So, Susan, stand up. This is Susan Sweat.

Kyle Stewart, my long-time administrative assistant, is in the back of the room. And Jamie Ellis, where are you? Jamie Ellis, stand up. Jamie Ellis is my new Veterans' Affairs staff member, and he will be working now in the Tupelo office. Thank you, Jamie. As many of you know, Bubba Lawler, for some 13-and-one-half years, was my veteran staffer. Well, he and his family surrendered to a call to the mission field, and they are now in Birmingham, England. I would be remiss if I did not recognize, in a public way, his great service for 13-plus years for the taxpayers in that regard. Jamie, we welcome you.

Again, we appreciate John Towers of Senator Burr's staff, and Aaron Sheldon of Senator Akaka's staff, for coming all this way and being part of this and for supplying me with information and suggestive questions.

Starting with Dr. Hojlo, would you like to summarize for 1 minute? And then we'll pass the microphone right on down.

Ms. HOJLO. Yes, sir. Once again, thank you for the opportunity to be present at this hearing. I would like to, just for the record, make it very clear that the Department of Veterans Affairs is extremely committed to moving forward with the agenda in transforming the culture of nursing home care, not only in the VA, but also contributing to that influence in the nursing home industry in the country. I think it is very courageous of you and your Committee to bring this to the front, because I think it is time that,

as a country, we start to address the plight of folks who have been assigned to needing nursing home care. And the circumstances in this country have not been ideal; so, I appreciate the fact that we are able to move this agenda forward through forums like this.

Senator WICKER. Thank you. Dr. Thomas?

Dr. THOMAS. I would like to say, first and foremost, thank you to Dr. Hojlo for the work she is doing, because she is there; she is responsible; she is the person with the obligation to move a giant bureaucracy forward, and I honor that.

Senator WICKER. As do I.

Dr. THOMAS. Yes. I want to say thank you for that. Second, I just want to say, if I may, I think that the Veterans' Affairs Committee and your leadership on that Committee can help Dr. Hojlo by providing the tools and support that is in the legislative language that can help her go farther faster.

Honestly, in the field of long-term care, we definitely have a debate about specific techniques, but it is very clear that long-term health care in America is moving in this direction, and our veterans need to benefit from that movement. I would like to strongly endorse the concept of giving Dr. Hojlo improved access to tools and resources to help her move her administration forward in this circle. Thank you.

Senator WICKER. Thank you very much. Mr. McAlilly?

Mr. MCALILLY. First, I want to say to you, thank you, again. We are honored that you and the Committee and the staff members are here for this hearing. It is an important time to you, and we're honored that you thought this idea was worthy enough to come to Tupelo. I think, to sum it up for me, the statement is, "you can't put new wine in old wineskins." And the research is there.

Senator WICKER. Where did you get that?

Mr. MCALILLY. Thirty years ago, we didn't know better, and we were doing the best that we could with what we knew. Twenty years ago and 10 years ago, we didn't know better. We were doing the best that we could with what we knew. Today we know better. There is a difference between food cooked in your home, where you can smell the bacon frying and hear the dishes rattling and the pots rattling, and sitting down at a 120-room dining hall, or even in a small pod and eating food that was delivered from the central kitchen on a cart to your area.

There is a difference between six friends sitting around their kitchen table playing rook and 45 people in the activity room at a bingo game. And there is a difference between being able to walk out of your bedroom and go into your den or even onto your patio and tend the flowers that you planted, versus 30 people lined up in the hall in their wheelchairs waiting. We know better today. We know better today; and the veterans of our country—those people who have given more than most of us—on this eve of our country's birthday—these people who have risked their lives and given it all—deserve the best that we can give them. And we believe that this model of care is the best that we can give them. Thank you.

Senator WICKER. Thank you. Mr. Jenkins?

Mr. JENKENS. I think I would like to go back to the quote from *The Wall Street Journal* article that you mentioned from Susan Feeney. I think what is interesting to me about that quote, as a

representative of the nursing home industry, is that she criticizes Bill's comments for being overly harsh. She did not criticize them for being unfair. And I think that is an important distinction.

I think nursing home providers want to change. As Steve says, they now know better, and they want to change. With courageous leadership, leadership like Steve's and Dr. Hojlo's, I think they will change. They will change by example. They will change by inspiration. But they need appropriate support, and they need appropriate resources to be effective in that change. And I think that's where the Committee can have a significant impact to help and assist in moving this forward. I would like to add my thanks for your work to both have the hearing and the work that you are pursuing to bring this as an option to the veterans. Thanks very much.

Senator WICKER. Thank you very much. And Dr. Cutler, I am tempted to say you have the last word, but actually, that lies with me.

Ms. CUTLER. Nor should I. I am speaking from our researchers' perspective with my remarks, and what we found with our research was that, compared to a traditional nursing home model, the Green Houses work. So, what I would ask, that as we go forward and do research—and we desperately need more research—that we not study setting, philosophy, organizational patterns, anything in isolation. It is the interrelationship of these three components of the Green Houses that make them work. And therefore, going forward, I applaud The Robert Wood Johnson Foundation for the organization to uphold these three principles. Because think of it as the three-legged stool. You take one leg out, and it is going to topple. So, not only research, that we research all of the three components' interrelationship, which we did in this study, but that—don't try to study the model in isolation. It needs—we need to look at the staff and how they interrelate with the elders, and how they interrelate with the family, and then, importantly, which has been somewhat ignored, how they interrelate with the professional staff, the home health component. And I thank you as well.

Senator WICKER. I thank you all. Let me take this opportunity not only to thank the panel and staff members, let me take this opportunity to, 1 day early, wish each of you a happy Independence Day and to point out to our guests in Tupelo that, until 1 p.m. today—and I am reading from the Northeast Mississippi Daily Journal—until 1 p.m. today, at One Mississippi Plaza at South Spring Street and Troy, there is a downtown Independence Day kickoff celebration featuring Kay Bain and the Morning Show Band with free hot dogs and lunch. So, you're all welcome to that until 1 p.m. today.

And we thank the veterans groups that came today and all of the interested citizens. Thank you to the media for helping us get the word out.

Mr. McAlilly, I am going to end with a quote that I used 5 years ago at the opening of the Green Houses in Tupelo. The veterans who are—and the elderly people who are—actually living in nursing care and living in the Green Houses, of course, can't be here today. But if I could be there and speak to them, I would say that the words of Tennyson are very appropriate to our regard for their service, and particularly the service of those who are veterans.

Where Tennyson says, "Though we are not now that strength which in old days moved earth and heaven, that which we are, we are. One equal temper of heroic hearts made weak by time and fate, but strong in will." And with those words of Tennyson, I salute our veterans, those in nursing care, and veterans everywhere on this, the eve of our Nation's birthday.

Thank you very much, and God bless America.

[Hearing concluded at 12:27 p.m.]

